PROGRAM OF

HOSPITAL-MEDICAL BENEFITS

For

Eligible Pensioners and Surviving Spouses

who retired on or after September 1, 2004

of

EMPIRE IRON MINING PARTNERSHIP

AND TILDEN MINING COMPANY L.C.

THE CLEVELAND-CLIFFS IRON COMPANY, Managing Agent

Pursuant to Agreement with

The United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union

Effective January 1, 2023

FOREWORD

This booklet is the summary plan description required by the Employee Retirement Income Security Act of 1974 (ERISA) of the Program of Hospital-Medical Benefits which has been established pursuant to the Pensioners' and Surviving Spouses' Health Insurance Agreement dated January 1, 2023, between Empire Iron Mining Partnership and Tilden Mining Company L.C., The Cleveland-Cliffs Iron Company, Managing Agent, and the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, which is reproduced as an addendum to this booklet. This booklet is applicable to hourly paid employees who retired on or after September 1, 2004 and their surviving spouses of Empire Iron Mining Partnership and Tilden Mining Company L.C., The Cleveland-Cliffs Iron Company, Managing Agent (hereafter referred to as "Empire Iron Mining Partnership and Tilden Mining Company L.C., The Cleveland-Cliffs Iron Company, Managing Agent" or the "Company"), whose headquarters are located at 200 Public Square, Suite 3300, Cleveland, OH 44114-2589, represented by the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (hereafter "Union"), whose headquarters are located at 60 Boulevard of the Allies, Pittsburgh, Pennsylvania 15222. This booklet constitutes a part of the Pensioners' and Surviving Spouses' Health Insurance Agreement, which continues until February 1, 2027 and thereafter, subject to negotiations between the Company and the Union which may take place no earlier than 2026.

Details relating to the operation of this Program will be included in reasonable rules, regulations and arrangements with insurance carriers.

The medical benefits under the Program are paid partly by the Company and partly by the pensioners and surviving spouses. Anthem Blue Cross/Blue Shield ("Anthem") administers the payment of medical claims. The prescription drug benefits are paid partly by the Company and partly by the pensioners and surviving spouses, and Express Scripts, Inc. (or its affiliate) administers the payment of claims.

The Pensioners' and Surviving Spouses' Health Insurance Agreement and the rules, regulations and arrangements referred to above form the basis on which the Program is administered, but if there is any inconsistency, such Insurance Agreement governs.

The name of the plan under which benefits are provided is the Program of Hospital-Medical Benefits for Eligible Pensioners and Surviving Spouses. The Company is liable for any benefits under the Program. The employer identification number assigned by the Internal Revenue Service is 34-1186059 for Empire Iron Mining Partnership and 38-2801658 for Tilden Mining Company L.C. and the Plan Numbers are 501. This is a welfare benefit plan as defined by ERISA.

Empire Iron Mining Partnership and Tilden Mining Company L.C., The Cleveland-Cliffs Iron Company, Managing Agent, 200 Public Square, Suite 3300, Cleveland, Ohio 44114, is the Plan Administrator, Plan Sponsor and agent for service of legal process under the Plan. The telephone number for the Plan Administrator is (216) 694-5700.

The Plan covers all hourly employees who retired on or after September 1, 2004, and their surviving spouses. The Plan is maintained pursuant to a collective bargaining agreement. As a

participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

(i) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as the local human resources office at your former place of employment, all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed for the plan with the U.S. Department of Labor, available at the Public Disclosure Room of the Employee Benefits Security Administration.

(ii) Obtain upon written request to the Plan Administrator copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

(iii) Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

(i) Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

(ii) Reduction or elimination of exclusionary periods of coverage for preexisting 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. If you need more information about your certificate of creditable coverage or want to request a certificate of creditable coverage, contact the Plan Administrator. 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.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court within 90 days of the denial. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-800-998-7542 or via the internet at www.dol.gov/ebsa/.

IMPORTANT NOTICE

Since the Program provides a Medicare Advantage Plan for those eligible for Medicare, it is essential that you and your dependents enroll for Medicare, including the voluntary Supplementary Medical Insurance provided under Part B of Medicare when eligible to do so. If you are not enrolled in Medicare Part A and Part B, you will not be eligible for benefits under the Medicare Advantage Plan.

Questions on medical benefits provided under the Program should be directed to Anthem Blue Cross/Blue Shield by calling 1-866-583-6288.

The claims administrators for the benefits described in this booklet are as follows:

NON-MEDICAL ELIGIBLE CONTACTS

Health Benefits:
Anthem Blue Cross and Blue Shield
P.O. Box 105187
Atlanta, GA 30348
www.anthem.com
1-866-583-6288

Prescription Drug Benefits:
Express Scripts, Inc.
P.O. Box 66301
St. Louis, MO 63166-6301
www.express-scripts.com
1-800-903-8662

COBRA/Direct Bill Administrator:
Cleveland-Cliffs Inc.
Employee Benefits Department
200 Public Square, Suite 3300
Cleveland, OH 44114
1-800-964-0153

MEDICARE ELIGIBLE CONTACTS

Anthem Blue Cross Blue Shield (Health, Prescription Drug, Dental, and Vision Benefits)
Member Services for Health, Dental Vision
1-833-812-1797

Member Services for Prescription Drug
1-833-360-3662

TABLE OF CONTENTS

HIGHLIGHTS OF PROGRAM OF HOSPITAL-MEDICAL BENEFITS

The following sections of this booklet contain a detailed explanation of the benefits and related provisions of the Program of Hospital-Medical Benefits. A summary is provided here to give you an initial overall view of the Program's main features.

LIFE INSURANCE

Your life insurance benefit is described in the Program of Insurance Benefits (PIB) for active employees at the time of your retirement. If you die after you have retired on pension and reached age 62, the amount of life insurance will be a reduced amount, as specified in the PIB in effect at the time of your retirement.

MEDICAL BENEFITS

You and your eligible dependents are covered by the Medical Benefits of this Program as detailed in Section 1. The Medical Benefits under the Program are administered by Anthem Blue Cross Blue Shield ("Anthem"), utilizing a Preferred Provider Organization (PPO) which is designed to cover all Medically Necessary confinements, services, supplies or treatments required to treat a definite condition of illness or injury that are not Experimental or Investigational. Certain preventive services are also covered under the Medical Benefits section of this Program. A PPO allows you to choose between two levels of care: In-Network or Out-of-Network. In-Network care is that which you receive from facilities and Professional Providers who participate in the PPO Network and are generally paid at a higher level. Out-of-Network care is that which you receive from facilities and Professional Providers who do not participate in the network and are subject to higher out-of-pocket expense. If you are covered by Medicare, then your benefits will be payable under the Medical and Prescription Drug Benefits for Medicare Eligible Participants, Section 3.This Program will coordinate with Medicare where applicable.

A detailed explanation is in Sections 1, 3, and 4.

PRESCRIPTION DRUG BENEFITS

You and your eligible dependents are covered by the Prescription Drug Benefits of this Program as detailed in Section 2, if you are a Non-Medicare Eligible. The Prescription Drug Benefits are administered by Express Scripts Holding Company.

You and your eligible dependents are covered by the Prescription Drug Benefits of this program as detailed in section 3, if you are Medicare Eligible. The Prescription Drug Benefits are administered by Anthem.

Prescription Drug Benefits are provided using a select drug list or formulary. The formulary is an extensive list of Food and Drug Administration ("FDA") approved prescription drugs selected for their quality, safety and effectiveness and includes products in every major therapeutic category. The Program provides coverage for both formulary and non-formulary drugs when purchased at the retail pharmacy or through the mail. A detailed explanation is in Section 2 and 3.

SECTION 1.
MEDICAL BENEFITS
FOR INDIVIDUALS NOT ELIGIBLE FOR MEDICARE
(For you and your dependents)

Introduction

1.0 You and your eligible dependents are covered by the medical benefits detailed in this Section 1 (the "Medical Benefits") if you are not eligible for Medicare. Your eligible dependents who are not eligible for Medicare are also covered by the medical benefits described in this Section. Medical Benefits under this Program are administered by the Claims Administrator listed in the Introduction of this Booklet (the "Claims Administrator"). The Medical Benefits of this Program are designed to cover all Medically Necessary and Appropriate, confinements, services, supplies or treatments required to treat a definite condition of illness or injury that are not Experimental or Investigational. This Medical Benefits Section also covers certain preventive services.

Participating Providers

1.1 Under the Medical Benefits of this Program, you have complete freedom of choice to utilize whichever medical services provider you choose. However, there are significant benefits to utilizing providers who participate in the Claims Administrator's Preferred Provider Organization ("PPO"). Such providers are called PPO or Network providers.

a. Benefits for the services of PPO providers are generally payable at up to 100% of the Allowable Charge (as opposed to generally up to 70% of the Allowable Charge if you use an Out-of-Network provider).

b. Benefits for services of PPO providers are not subject to a Deductible, whereas benefits for services of Out-of-Network providers are generally subject to a Deductible.

c. PPO providers will accept the Claims Administrator's determination of the Allowable Charge and will not bill you for more than the Copayment required by this Program; Out-of-Network providers may balance bill you for the difference between their charge and the amount paid by the Claims Administrator.

d. If you use a PPO in-network hospital or facility, any services provided by hospital-based providers such as radiologists, anesthesiologists, pathologists, and assistant surgeons will be paid at the in-network level regardless of whether that provider is in the network.

e. In-network benefits will be paid if a PPO provider refers you to a physician, specialist, hospital or other provider that is not in the PPO network, or if a PPO provider is not available.

f. PPO providers will receive reimbursement for services directly from the Claims Administrator and will bill you only for your Copayment; Out-of-Network

providers may bill you for their entire fee with the result that you will have to file a claim form to obtain reimbursement for the portion of the Allowable Charge payable under this Section.

g. You can call the number on your I.D. card for information on the nearest PPO participating providers or to determine if a particular provider is in the Network or to find out how to obtain a list of PPO providers.

Terms You Should Know

1.2 As used herein:

a. Allowable Charge (*also called "Provider's Reasonable Charge*") - is the dollar amount that the PPO has determined is reasonable for Covered Services provided under this Section. This is an important term to know if you go outside the Network for care. The amount paid under this Section for Out-of-Network care is based on the Allowable Charge – not the provider's actual charge.

b. Nurse On Call[SM] - is a 24-hour, 7 days a week health decision support number that provides health care information.[1]

c. Claim - is a request for precertification or prior approval of a Covered Service or for the payment or reimbursement of the charges or costs associated with a Covered Service.

d. Coinsurance - is the percentage of the Allowable Charge paid under this Section; the remaining percentage is the percentage you pay.

e. Copayment (or copay) - is the fixed up-front dollar amount you pay for certain covered expenses. This amount will be deducted from the provider's reasonable charge before a determination of benefits payable is made under this Section. The Copayment you are required to pay does not vary with the cost of the services. You are expected to pay the provider at the time of service.

f. Covered Services - are the services, confinements, supplies, and/or treatments you receive from an Eligible Provider, as defined in paragraph 1.21 below, to the extent they are (1) determined to be Medically Necessary and Appropriate, and (2) specifically identified in paragraphs 1.22 - 1.80 below, subject to modification by mutual agreement of the Company and the Union. However, such Covered Services are subject to the limitations, Deductibles, and Copayments outlined in this Section.

g. Deductible - is the initial amount you must pay each year for Covered Services before payment for benefits begins under this Section.

[1] Nurse On Call is a service mark of the Blue Cross Blue Shield Association.

To assist employees with several covered dependents, the Deductible you pay for the entire family, regardless of its size, is specified under "Family" Deductible. To reach this total, you can count the expenses incurred by two or more family members. However, the Deductible contributed toward the total by any one family member cannot be more than the amount of the Individual Deductible. If one family member meets the Individual Deductible and again needs to use benefits, payment for that person's Covered Services will begin even if the Family Deductible has not been met.

h. Experimental/Investigative - is the use of any treatment, service, procedure, facility, equipment, drug, device or supply (intervention) which is not medically effective for the condition being treated. The Claims Administrator will consider an intervention to be Experimental/Investigative if:

(1) the intervention does not have Food and Drug Administration ("FDA") approval to be marketed for the specific relevant indication(s);

(2) available scientific evidence does not permit conclusions concerning the effect of the intervention on health outcomes;

(3) the intervention is not proven to be as safe or as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies;

(4) the intervention does not improve health outcomes; or

(5) the intervention is not proven to be applicable outside the research setting.

Covered exceptions to this policy shall include: (1) MRIs for breast cancer screening where there is personal history OR dense breasts; and (2) use of IMRT for one or both breasts during cancer treatment, whether or not a mastectomy has been performed.

i. Lifetime Maximum - is the maximum amount of Medical Benefits that will be provided for any covered individual during their lifetime while covered under this Section of the Program, as outlined in paragraph 1.3.

At the start of each calendar year, up to $1,000 in Medical Benefits paid in the prior calendar year will be restored to the Lifetime Maximum of each covered member, provided such member had medical expenses payable in excess of $1,000 and they were not covered by Medicare. Medicare recipients are not eligible for restoration of the Lifetime Maximum.

j. Medical Emergency - is a medical condition with acute symptoms of severity or severe pain for which care is sought as soon as possible after the medical condition becomes evident and the absence of immediate medical attention could result in: placing health in serious jeopardy; serious impairment of bodily functions; serious dysfunction of any body part and/or other serious medical consequences.

Notwithstanding any provisions to the contrary, coverage for visits for ambulance services and emergency care will be evaluated using a prudent layperson standard: whether from the perspective of an ordinary person, the patient's condition, judged based on presenting symptoms, reasonably warranted immediate attention.

k. Medically Necessary - Health Care Benefits under the Program are payable only if the services rendered are medically necessary. Medically necessary means that the services and supplies in question are medically reasonable and necessary for the diagnosis or treatment of an illness or accidental injury and are given at the appropriate level of care. The fact that a procedure or level of care is prescribed by a physician does not mean that it is medically reasonable or necessary. In determining questions of reasonableness and necessity, due consideration shall be given to the customary practices of physicians in the community where the service is performed. Services which are not reasonable and necessary shall include, but are not limited to the following:

(1) procedures which are experimental or of unproven or questionable current usefulness;

(2) procedures which tend to be redundant when performed in combination with other procedures;

(3) diagnostic procedures which are unlikely to provide a physician with additional information when they are used repeatedly;

(4) procedures which are not ordered by a physician or which are not documented in timely fashion in the patient's medical record; and

(5) procedures performed in an inpatient setting which could be performed with equal safety and effectiveness in an outpatient setting or treatment which can be performed with equal efficiency and quality at a lower level of care.

l. Out-of-Pocket Limit - is the highest dollar amount for which you are responsible each year before 100% (except for required Copayments) of all covered expenses are paid under this Section. The Out-of-Pocket Limit includes Coinsurance and Deductibles, but does not include Mental/Nervous, Substance Abuse, prescription drug expenses or expenses in excess of the Allowable Charge.

To help employees with several covered dependents, the out-of-pocket amount you pay for the entire family, regardless of its size, is specified under "Family" Out-of-Pocket Limit in paragraph 1.3. To reach this total, you can count the expenses paid by two or more family members. However, the out-of-pocket expenses contributed toward the total by any one family member cannot be more than the amount of the Individual Out-of-Pocket Limit. If one family member meets the Individual Out-of-Pocket Limit and again needs to use benefits, payment would begin at 100% (except for required Copayments) for that person's Covered Services even if the Family Out-of-Pocket Limit has not been met.

m. Precertification - is a process through which it is determined whether certain services, confinements, supplies, and treatments are Medically Necessary and Appropriate.

n. Preferred Provider Organization (PPO) - is the provider network made up of physicians, specialists, hospitals and other health care facilities in the PPO Network that is used by the Claims Administrator. This provider network helps assure that you receive maximum coverage under this Section.

Summary of Medical Benefits

1.3 This Summary of Benefits provides an overview of the Medical Benefits available to you. Please refer to the subsequent pages for a more detailed description of Covered Services, limitations and exclusions.

SUMMARY OF MEDICAL BENEFITS		
Benefits	**In-Network**	**Out-of-Network**
Deductible Individual Family	 None None	 $300 $600
Coinsurance	90%	70% after Deductible
Out-of-Pocket Limits Individual Family	 $1,000 $2,000	 $2,000 $4,000
Balanced Billing	None	Possible
Lifetime Maximum	$5,000,000	
Physician Office Visits	100% after $15 Copay	70% after Deductible
Preventive Care *Adult* Routine physical exams Routine GYN exams including PAP tests Mammograms as required *Pediatric* Routine physical exams Pediatric immunizations	 100%, no Copay 100%, no Copay 100%, no Copay 100%, no Copay 100%, no Copay	 70% after Deductible 70% after Deductible 70% after Deductible 70% after Deductible 70% after Deductible
Emergency Room Services Physician services	100%, no Copay	70% after Deductible
Emergency Room Services Facility Charges	100% after $40 Copay (which is waived if you are admitted)	

SUMMARY OF MEDICAL BENEFITS		
Benefits	**In-Network**	**Out-of-Network**
Ambulance Service (including Air Ambulance)	100%	100%
Hospital Services Inpatient Outpatient	 90% 90%	 70% after Deductible 70% after Deductible
Hearing Aids	100%	80% after Deductible
	Benefits limited to $2,000 per ear every three years	
Maternity Services	90%	70% after Deductible
Infertility counseling, testing and treatment	90%	70% after Deductible
Assisted Fertilization Procedures	Excludes all assisted fertilization procedures	
Medical/Surgical/Physician Services (except office visits)	90%	70% after Deductible
Spinal Manipulations	100% after $15 Copay	70% after Deductible
	Combined Limit: 26 visits per calendar year	
Anesthesia Services	90%	70% after Deductible
Diagnostic Services (Lab, X-ray, Standard Imaging, and other tests)	100%	
Advanced Imaging (CT scan, CTA, MRI, MRA, PET scan, PET/CT scan	90%	70% after Deductible
Radiation and Chemotherapy (including freestanding facilities)	90%	70% after Deductible
Physical Therapy (Professional)	100% after $15 Copay	70% after Deductible
Occupational Therapy (Professional)	100% after $15 Copay	70% after deductible
	PT and OT Combined Limit: 60 visits per calendar year	
Speech Therapy (Professional)	100% after $15 Copay	70% after Deductible
	Limit: 20 visits per calendar year	
Durable Medical Equipment	90%	70% after Deductible
Orthotics and Prosthetics	90%	70% after Deductible
Skilled Nursing Facility Services	90%	70% after Deductible
	Combined Limit: 100 days per calendar year	
Home Health Care	90%	70% after Deductible, limit 30 visits per calendar year
Private Duty Nursing	90%	

SUMMARY OF MEDICAL BENEFITS		
Benefits	**In-Network**	**Out-of-Network**
	\$10,000 maximum per calendar year	
Hospice Care	100%	
Birthing Center	90%	70% after Deductible
Well Baby Care	90%	70% after Deductible
Transplant Services	90%	70% after Deductible
Mental Health Services *Inpatient*	90%	50% after Deductible
	Combined Limit: 45 days per calendar year (including residential treatment centers)	
Outpatient	100% after \$15 Copay	70% after Deductible
	Combined Limit: 50 visits per calendar year	
Substance Abuse Services *Inpatient*	90%	70% after Deductible
	Detoxification: 7 days per admission and two admissions per lifetime	
	Rehabilitation: 45 days per calendar year and two admissions per lifetime	
Outpatient	100% after \$15 Copay for initial visit, 100% thereafter	70% after Deductible
	50 visits per calendar year	10 visits per calendar year
Other Covered Services	90%	70% after Deductible
Precertification Requirements	Performed by Member	

Note: The percentages shown in the above table refers to the portion of Allowable Charge for a Covered Service which are paid by the Plan (see 1.2(a)). The remaining percentage is the amount you are required to pay.

Blue Cross/Blue Shield Identification

1.4 The Claims Administrator will issue you an Identification (I.D.) Card. It is recommended that you carry your I.D. card with you at all times and destroy any previously issued cards.

1.5 **When you or one of your dependents receives health care services:**

(1) show your I.D. card to the hospital, physician, or other professional health care providers; and

(2) ask the provider to file a Claim for you.

1.6 **The following information will be displayed on your I.D. card:**

(1) Your name;

(2) I.D. number (an alpha prefix followed by your Unique Member Identifier Number);

(3) Group number;

(4) Copayment for In-Network physician office visits and emergency room visits;

(5) Member Service toll-free number (on back of card);

(6) Precertification toll-free number (on back of card); and

(7) "PPO in Suitcase" symbol.

Protect Your Card

1.7 If your card is lost or stolen, please contact the Claims Administrator immediately. Your card is only to be used by persons who are covered under the Medical Benefits Section of this Program.

1.8 To request additional I.D. cards, contact Member Service at the number listed on your I.D. card.

Medically Necessary and Appropriate

1.9 For benefits to be paid under this Section, at either the In-Network or Out-of-Network level, services and supplies must be considered Medically Necessary.

Precertification (Required for Inpatient Admissions)

1.10 Prior to a non-emergency admission to a Facility Provider (hospital, alcohol or drug rehabilitation facility, skilled nursing facility, birthing center or hospice), you must obtain certification from the Claims Administrator to determine whether your confinement is Medically Necessary and Appropriate for purposes of reimbursement. Accordingly, you should contact the Claims Administrator by calling the precertification telephone number listed on your I.D. card. For an emergency or maternity admission, you must contact the Claims Administrator within 48 hours following admission, or as soon as is reasonably possible.

1.11 Whether you are to be admitted to an In-Network facility or Out-of-Network facility, you, not the provider, are responsible for notifying or insuring that the Claims Administrator is notified of your admission.

1.12 A Claims Administrator nurse reviewer will review your inpatient admission to ensure it is:

- appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury;
- provided for your diagnosis or the direct care and treatment of your condition, illness, disease or injury;
- not primarily for the convenience of you, your physician, hospital or health care provider;
- in accordance with standards of good medical practice;
- being delivered in the appropriate setting; and
- the most appropriate service that can safely be provided.

1.13 If the nurse reviewer is unable to authorize your admission, your case will be referred immediately to a Claims Administrator physician for a determination. The Claims Administrator physician may authorize your admission. Alternatively, the Claims Administrator physician may determine that one or more days of the proposed hospital admission are unnecessary and that the same services can be provided in an outpatient setting, such as outpatient testing, outpatient surgery or observation. If the Claims Administrator physician does not authorize your inpatient admission, you and your physician will be notified by letter, and if necessary, by telephone. You and your physician can then decide to appeal the denial of your hospital admission or to proceed and obtain services in an alternate setting.

1.14 If you do not obtain certification for your admission to a Facility Provider, the Claims Administrator will review your care after services are received to determine if it was Medically Necessary and Appropriate. *If the admission is determined not to be Medically Necessary and Appropriate, you will be responsible for costs not covered.*

Discharge Planning

1.15 Discharge planning is a review of the case to identify your discharge needs. The process begins prior to admission and extends throughout your stay in a facility. Discharge planning ensures continuous, quality care and is coordinated with input from your physician.

1.16 To plan effectively, the Claims Administrator Care Manager assesses your:

- level of function pre- and post-admission;
- ability to perform self-care;
- primary caregiver and support system;

- living arrangements pre- and post-admission;
- special equipment, medication and dietary needs;
- obstacles to care;
- need for referral to Case Management or Disease Management; and
- availability of benefits or need for benefit adjustments.

1.17 Once continued confinement is determined to be no longer necessary, the Claims Administrator and your physician will discuss plans for discharge or for a continued course of treatment in an alternate setting, provided that an alternate setting for less acute care is immediately available. If a less acute care setting is not available within a reasonable distance, full benefits will be provided for your continued confinement until such care is available. The Claims Administrator will notify you, your physician and the hospital by telephone if a determination is made that your confinement is no longer necessary or that an alternate setting is available. *If you continue to stay in the facility beyond the date specified by the Claims Administrator, you will be responsible for all inpatient facility charges subsequent to such date*.

Individual Case Management Services

1.18 Individual Case Management, which concentrates on those cases where the early identification of catastrophic and chronic illnesses or injuries can enhance the quality of care and recovery, is available. A catastrophic case typically involves the following types of illnesses or injuries.

Illnesses	Injuries
Neonatal High Risk Infant	Major Head Trauma
Cerebrovascular Accident	Spinal Cord Injury
Cardiac Surgery	Amputations
Multiple Sclerosis	Multiple Fractures
Muscular Dystrophy	Severe Burns
Cerebral Palsy	Chronic Back Injuries
AIDS	Knee Injuries

1.19 **Individual Case Management can help:**

- coordinate a treatment plan to enable you to reach optimum recovery in a timely manner;
- identify alternatives to an acute care setting such as rehabilitative therapies or specialized home care services when appropriate;

- provide benefits for confinements, services, supplies, equipment and treatments which would not otherwise be covered under the Program provided that, in the sole judgment of the Claims Administrator acting on behalf of the Program, the provision of benefits not otherwise required under the Program represent a less costly means (from the standpoint of the Program) of providing the care required by the patient;

- work with you to obtain the maximum level of health care coverage.

Eligible Providers

1.20 To be covered under this Section, services must be obtained from one or more of the following types of providers ("Eligible Providers"). Services obtained from providers other than Eligible Providers will not be covered even if they would have been covered had they been obtained from Eligible Providers.

a. Facility Providers

- Hospitals
- Psychiatric Hospitals
- Rehabilitation Hospitals
- Alcohol abuse treatment facility
- Ambulance service
- Ambulatory surgical facility
- Birthing facility
- Day/Night psychiatric facility
- Drug abuse treatment facility
- Freestanding radiation facility
- Freestanding dialysis facility
- Freestanding gambling addiction treatment facility
- Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility
- Home health care agency
- Home infusion therapy provider
- Hospice
- Outpatient alcohol abuse treatment facility
- Outpatient drug abuse treatment facility
- Outpatient physical rehabilitation facility
- Outpatient psychiatric facility
- Pharmacy provider
- Residential treatment facility for alcohol and substance abuse
- Skilled nursing facility

b. Professional Providers

- Audiologist
- Certified registered nurse*
- Chiropractor

- Clinical laboratory
- Dentist
- Licensed certified master-level social workers**
- Nurse-midwife
- Nurse practitioner
- Occupational therapist
- Optometrist
- Physician's assistant
- Physical therapist
- Physician
- Podiatrist
- Psychologist
- Registered nurses (RNs) and licensed practical nurses (LPNs)***
- Respiratory therapist
- Speech-language pathologist
- Teacher of hearing impaired

* Excluded from eligibility are registered nurses employed by a health care facility or by an anesthesiology group.
** For mental health and substance abuse services**.**
*** For skilled nursing care.

Covered Services

1.21 This Program provides benefits for the following confinements, services, supplies and treatments you receive from an Eligible Provider when such services are determined to be Medically Necessary and Appropriate. All Deductibles, Copayment amounts, Coinsurance levels, Out-of-Pocket Limits and frequency limitations are described in the Summary of Medical Benefits outlined in paragraph 1.3. Covered Services include the services, confinements, supplies, and treatments provided in paragraphs 1.22 - 1.80.

REMEMBER: In-Network care is covered at a higher level of benefits than Out-of-Network care.

Routine and Preventive Care

1.22 **Adults 18 Years of Age and Older - Routine Physical Examinations**

The Program covers services for Routine and Preventive Care (which are not subject to a copay or deductible). Preventive Care benefits may vary based on the age, sex, and personal history of the individual. Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service. Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the benefits applicable to diagnostic services.

Some examples of Preventive Care Covered Services are routine or periodic exams. Examinations include, but are not limited to:

(a) Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines.

(b) Child health supervision services includes, but is not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests. Please refer to the Periodic Exam Table following this section for visit intervals.

(c) Adult routine physical examinations.

(d) Pelvic examinations.

(e) Routine EKG, Chest XR, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.

(f) Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). For adults, the Plan follow the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians. These include, but are not limited to:

- Hepatitis A vaccine
- Hepatitis B vaccine
- Hemophilus influenza b vaccine (Hib)
- Influenza virus vaccine
- Rabies vaccine
- Diphtheria, Tetanus, Pertussis vaccine
- Mumps virus vaccine
- Measles virus vaccine
- Rubella virus vaccine
- Poliovirus vaccine
- Human Papilloma Virus
- Herpes Zoster vaccine (“Shingles”)

1.23 **Children Under Age 18 - Pediatric Care and Immunizations**

Pediatric preventive services cover one examination during each of the age categories in the table below. Benefits are not subject to the Program Deductibles or maximums and are limited to eligible dependents under age 18.

Pediatric Periodic Physical Exam (once during each age category)	
Newborn	5 years
By 1 month	6-7 years
2 months	8-9 years
4 months	10 years
6 months	11 years
9 months	12 years
12 months	13 years
15 to 18 months	14 years
24 months	15 years
3 years	16 years
4 years	17 years

1.24 **Screening Examinations**

Coverage for Routine and Preventive Care also includes certain screening services (which are not subject to a copay or deductible). These include, but are not limited to:

(a) Routine screening mammograms; additional mammography views required for proper evaluation and any ultrasound services for screening of breast cancer;

(b) Routine cytologic and chlamydia screening (including pap test);

(c) Routine bone density testing for women;

(d) Routine prostate specific antigen testing;

(e) Routine colorectal cancer examination and related laboratory tests.

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

1.25 **Routine Gynecological Examination and Pap Test (not subject to a copay or deductible):**

(a) Women, regardless of age, are covered for one routine gynecological examination, including a pelvic and clinical breast examination, and one routine Papanicolaou smear (pap test) per calendar year. Benefits are not subject to Program Deductibles or maximums.

(b) Women age 19-26 and girls are covered for the Human Papilloma Virus (HPV) Vaccine. Benefits are not subject to Program Deductibles or maximums.

(c) HPV tests are also covered for women, regardless of age, when recommended by a physician.

Care of Illnesses and Injuries

Physician Visits

1.26 The following services are covered:

- outpatient medical care rendered that is not related to surgery, pregnancy or mental illness, except as specifically provided herein; and
- medical care visits and consultations to examine, diagnose and treat an injury or illness.

Responsive Emergency Care

1.27 Emergency room visits made in or outside the PPO Network are covered at the higher, In-Network level of benefits.

1.28 Your outpatient emergency room visits are subject to a Copayment, which is waived if you are admitted as an inpatient.

1.29 If the reason for your visit is determined not to be a Medical Emergency and you receive care at an Out-of-Network hospital, your benefits will be subject to the Out-of-Network Deductible and Coinsurance provisions of this Section. Such visits for emergency care will be evaluated using a prudent layperson standard: whether from the perspective of an ordinary person, the patient's condition, judged based on presenting symptoms, reasonably warranted immediate attention.

Facility Services

1.30 The Program covers the services outlined in paragraphs 1.31 - 1.34 below that you receive in a hospital or other Facility Provider.

Bed, Board and General Nursing Services

1.31

- In a semi-private room**.**
- In a private room with the allowance limited to the average semi-private room charge.

- In a bed in a Special Care Unit which gives intensive care to the critically ill.

Other Services

1.32

- Operating, delivery and treatment rooms and equipment.
- Drugs and medicines provided to you while you are an inpatient in a hospital or other Facility Provider.
- Whole blood, administration of blood, blood processing, and blood derivatives.
- Anesthesia, anesthesia supplies and services rendered in a hospital or other Facility Provider by an employee of the hospital or other Facility Provider.
- Administration of anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery.
- Medical and surgical dressings, supplies, casts and splints.
- Diagnostic services.
- Therapy services.
- Inpatient Admissions and Outpatient Visits-Dental Cases

  Hospital benefits provided under the Program are available:

  (a) If you are admitted to a hospital

  (i) for extraction of impacted teeth, or

  (ii) for extraction of teeth other than impacted teeth or for other dental processes provided hospitalization is certified by a licensed physician or a doctor of dental surgery as being necessary to safeguard the health of the person confined;

  (iii) for any oral surgery or emergency care.

  (b) if you receive treatment in the outpatient department of a hospital for

  (i) extraction of impacted teeth, or

  (ii) extraction of teeth other than impacted teeth or for other dental processes, provided hospital outpatient care is necessary to safeguard the health of the patient.

Surgery

1.33 Hospital services and supplies for outpatient surgery including removal of sutures, anesthesia, and anesthesia supplies and services furnished by an employee of the hospital or other Facility Provider, other than the surgeon or assistant at surgery are covered.

Pre-Admission Testing

1.34 Coverage is provided for outpatient tests and studies required for your scheduled admission as an inpatient.

Medical/Surgical Services

1.35 The Program covers the services outlined in paragraphs 1.36 - 1.40 that you receive from a Professional Provider.

Surgical Services

1.36 Surgery performed by a Professional Provider is a Covered Service. Payment includes visits before and after surgery.

a. When more than one surgical procedure is performed by the same Professional Provider during the same operation, the total benefits payable will be the amount payable for the highest paying procedure plus 50% of the amount that would have been payable for each of the additional procedures had those procedures been performed alone. Refer to Section 1.1(c).

b. Sterilization procedures such as tubal ligation and vasectomy are covered, regardless of whether Medically Necessary and Appropriate.

c. Elective abortions are covered where permitted by law.

d. Oral surgery benefits are provided for the following limited oral surgical procedures in an outpatient setting when preauthorized by the Claims Administrator (acting on behalf of the Program) or in an inpatient setting if determined to be Medically Necessary and Appropriate:

- extraction of teeth in preparation for radiation therapy;
- mandibular staple implant when not done to prepare the mouth for dentures;
- Facility Provider and anesthesia services rendered in conjunction with a non-covered dental procedure when determined to be Medically Necessary due to the member's age and/or medical condition;
- accidental injury to the jaw or structures contiguous to the jaw;
- the correction of a non-dental physiological condition which has resulted in a severe functional impairment;

- treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof and floor of the mouth;
- orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

e. A mastectomy performed on an inpatient or outpatient basis, as well as surgery to re-establish symmetry or alleviate functional impairment is covered, including but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy, as required under the Women's Health and Cancer Rights Act of 1998 or if needed as a result of an accident. Physical complications of all stages of mastectomy are also covered, including lymphedemas. Also covered are the use of initial and subsequent prosthetic devices to replace the removed breast or portions thereof and one home health care visit within 48 hours after discharge, as determined by your physician, if discharge occurred within 48 hours after admission for a mastectomy.

f. Medically necessary oral surgical procedures related to temporomandibular joint dysfunction (TMJ).

Assistant At Surgery

1.37 Services of a physician who actively assists the operating surgeon in performing covered surgery if a house staff member, intern or resident is not available are covered.

Anesthesia

1.38 Administration of anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or the assistant at surgery is covered. Benefits will also be provided for the administration of anesthesia for oral surgical procedures covered under this Section and performed in an outpatient setting when ordered and administered by the attending Professional Provider.

Second Surgical Opinion

1.39 A second physician's opinion and related diagnostic services to help determine the need for elective covered surgery recommended by your first physician are covered.

Keep in mind that:

- your second opinion must be from someone other than your first physician who recommended the elective surgery;
- elective surgery means non-emergency surgery or surgery that may be deferred; and
- a third opinion is covered if the first and second opinions conflict.

1.40 If the consulting opinion is against elective covered surgery and you decide to have the elective surgery, the surgery is a Covered Service. In such instance, you will be eligible for a maximum of two such consultations involving the elective surgical procedure in question, but limited to one consultation per consultant.

Inpatient Medical Services

1.41 The following services you receive from a Professional Provider are covered when you are an inpatient for a condition not related to surgery, pregnancy or mental illness:

a. Inpatient Medical Care Visits

b. Intensive Medical Care

(1) Constant attendance and treatment by a Professional Provider when your condition requires it for a prolonged time.

c. Concurrent Care

(1) Care for a medical condition by a Professional Provider who is not your surgeon while you are in the hospital for surgery.

(2) Care by two or more Professional Providers during one hospital stay when the nature or severity of your condition requires the skills of separate physicians whose specialty is unrelated.

d. Consultation

(1) Consultation by another Professional Provider when requested by the attending Professional Provider. Staff consultations required by hospital rules are excluded.

e. Newborn Care

(1) Professional Provider visits to examine the newborn infant while the mother is an inpatient.

Ambulance Service

1.42 The Program provides coverage for local transportation by a specially designed and equipped vehicle used only to transport the sick and injured:

- from your home, the scene of an accident or Medical Emergency to a hospital;
- between hospitals;
- between a hospital and a skilled nursing facility;
- from a hospital to your home;

- from a skilled nursing facility to your home; or

- air ambulance services when ordered by the attending physician or other emergency response personnel in conjunction with acute or life saving care

1.43 Trips must be to the closest local facility that can provide Covered Services appropriate for your condition. If there is no facility in the local area that can provide Covered Services appropriate for your condition, you are covered for trips to the closest such facility outside your local area that can provide the necessary service.

Maternity Care

1.44 If you think that you are pregnant, the Medical Benefits Section of this Program covers your contact with your physician and visit to an obstetrician or nurse midwife. When your pregnancy is confirmed, you are covered for follow up care which includes prenatal visits, sonograms, delivery, and postpartum and newborn care.

Maternity Home Health Care Visit

1.45 You are covered for one maternity home health care visit provided at your home within 48 hours of discharge when the discharge from a Facility Provider occurs prior to: (a) 48 hours of inpatient care following a normal vaginal delivery or (b) 96 hours of inpatient care following a cesarean delivery. This visit is covered if made by a Network provider whose scope of practice includes postpartum care. The visit includes parent education, assistance and training in breast and bottle feeding, infant screening, clinical tests, and the performance of any necessary maternal and neonatal physical assessments. The visit may, at your sole discretion, occur at the office of your Network provider. The visit is subject to all the terms of this Section and is exempt from any Copayment, Coinsurance or Deductible amounts.

Diagnostic Services

1.46 Covered services include the following when ordered by an eligible Professional Provider:

a. diagnostic x-ray consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;

b. diagnostic pathology consisting of laboratory and pathology tests;

c. diagnostic medical procedures consisting of electrocardiogram, electroencephalogram, and other electronic diagnostic medical procedures and physiological medical testing approved by the Claims Administrator; and

d. allergy testing consisting of percutaneous, intracutaneous, and patch tests.

Therapy Services

1.47 The following services you receive from an eligible Professional Provider are covered. See the Summary of Benefits in paragraph 1.3 for any benefit limitations.

- radiation therapy;
- chemotherapy;
- dialysis treatment;
- physical therapy;
- respiration therapy;
- occupational therapy;
- speech therapy;
- infusion therapy; and
- cardiac rehabilitation.

Spinal Manipulations

1.48 Coverage is provided for spinal manipulations for the detection and correction, by manual or mechanical means, of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column. See the Summary of Benefits in paragraph 1.3 for any benefit limitations.

Home Infusion Therapy Services

1.49 Services provided by a home infusion therapy provider in a home setting are covered, including pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with home infusion therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with home infusion therapy.

Private Duty Nursing Services

1.50 Coverage is provided for the services of a Registered Nurse (RN) or Licensed Practical Nurse (LPN) when ordered by a physician, provided the nurse does not ordinarily reside in your home or is not a member of your immediate family and:

- If you are an inpatient in a hospital or other Facility Provider, only when the Claims Administrator determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by the regular nursing staff.

- If you are at home, only when the Claims Administrator, on behalf of the Plan Administrator, determines that the nursing services require the skills of an RN or an LPN.

Skilled Nursing Facility Services

1.51 The Program covers services rendered in a skilled nursing facility to the same extent benefits are available to an inpatient of a hospital.

1.52 ***No Benefits are Payable under this Section for Skilled Nursing Facility Services:***

- after you reach the maximum level of recovery possible for your particular condition and no longer require definitive treatment other than routine supportive care;

- when confinement is intended solely to assist you with the activities of daily living or to provide an institutional environment for your convenience; or

- for treatment of alcohol abuse, drug abuse or mental illness.

Home Health Care/Hospice Care Services

1.53 The Program covers the following services you receive from a home health care agency, hospice or a hospital program for home health care and/or hospice care:

a. skilled nursing services of an RN or LPN, excluding private duty nursing services;

b. physical therapy, occupational therapy and speech therapy;

c. medical and surgical supplies provided by the home health care agency or hospital program for home health care or hospice care;

d. oxygen and its administration;

e. medical social service consultations;

f. health aide services when you are also receiving covered nursing or therapy services;

g. family counseling related to your terminal condition; and

h. hemodialysis.

1.54 ***No Home Health Care/Hospice Care Benefits will be provided under this Section for:***

a. dietician services;

b. homemaker services;

c. maintenance therapy;

d. custodial care; or

e. food or home delivered meals.

Dental Services Related to Accidental Injury

1.55 Dental services rendered by a physician or dentist which are required as a result of accidental injury to the jaws, sound natural teeth, mouth or face are covered. Injury caused by chewing or biting will not be considered accidental.

Durable Medical Equipment

1.56 Coverage is provided for the rental or, at the option of the Claims Administrator, the purchase, adjustment, repairs and replacement of durable medical equipment for therapeutic use when prescribed by a Professional Provider. Rental costs cannot exceed the total cost of purchase.

Hearing Aids

1.57 Hearing aids including digital aids, and examinations for the fitting of hearing aids once every three years if (a) the hearing aid is prescribed by an otolaryngologist (ear, nose and throat specialist) or (b) the replacement is certified as necessary by an otolaryngologist and such replacement occurs more than three years after the later of the installation of the initial hearing aid or the last replacement of the hearing aid. Benefits are limited to $2,000 per ear every three years.

Prosthetic Appliances

1.58 The Program covers the purchase, fitting, necessary adjustments, repairs, and replacements of prosthetic devices and supplies that:

a. replace all or part of a missing body organ and its adjoining tissues; or

b. replace all or part of the function of a permanently inoperative or malfunctioning body organ.

Dental appliances are not covered.

Orthotic Devices

1.59 The purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device which restricts or eliminates motion of a weak or diseased body part is covered.

Transplant Services

1.60 The Program provides benefits for Covered Services furnished by a hospital which are directly and specifically related to the transplantation of organs, bones or tissue.

1.61 If a human organ, bone or tissue transplant is provided from a living donor to a human transplant recipient:

a. when both the recipient and the donor are covered by this Program, each is entitled to the benefits of this Program;

b. when only the recipient is covered by this Program, both the donor and the recipient are entitled to the benefits of this Program subject to the following additional limitations: (1) the donor benefits are limited to only those not provided or available to the donor from any other source, including but not limited to, other insurance coverage, including other coverage provided by any Claims Administrator, or any government program, and (2) benefits provided to the donor will be charged against the recipient's coverage under this Program;

c. when only the donor is covered by this Program, the donor is entitled to benefits, subject to the following additional limitations: (1) the benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this Program, and (2) no benefits will be provided to the non-covered transplant recipient; and

d. if any organ or tissue is sold rather than donated to the covered recipient, no benefits will be payable for the purchase price of such organ or tissue; however, other costs related to evaluation and procurement are covered up to the covered recipient's Program limit.

Enteral Formulae

1.62 Coverage is provided for enteral formulae when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders. Benefits for such enteral formulae are exempt from any applicable Deductible requirements.

1.63 Enteral formulae is a liquid source of nutrition administered under the direction of a physician which may contain some or all the nutrients necessary to meet minimum daily

nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube.

1.64 Additional coverage for enteral formulae is provided when administered on an outpatient basis, when Medically Necessary and Appropriate for your medical condition, when considered to be the sole source of nutrition and:

a. when provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulas; or

b. when provided orally and identified as one of the following types of defined formula:

- with hydrolyzed (pre-digested) protein or amino acids; or
- with specialized content for special metabolic needs; or
- with modular components; or
- with standardized nutrients.

These additional benefits are subject to the Program Deductible and maximum amounts, if applicable. Once it is determined that you meet the above criteria, coverage for enteral formulae will continue as long as it represents at least 50% of your daily caloric requirement.

1.65 ***Coverage for Enteral Formulae Excludes the Following:***

- blenderized food, baby food, or regular shelf food when used with an enteral system;
- milk or soy-based infant formulae with intact proteins;
- any formulae, when used for the convenience of you or your family members;
- nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance;
- the following formulae when provided orally; semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; and
- normal food products used in the dietary management of rare hereditary genetic metabolic disorders.

Diabetes Treatment

1.66 The Program provides coverage for the following when required in connection with the treatment of diabetes and when prescribed by a physician legally authorized to prescribe such items under the law:

a. Equipment and supplies: Blood glucose monitors, monitor supplies, injection aids, syringes and insulin infusion devices; and

b. Outpatient Diabetes Education: When your physician certifies that you require diabetes education as an outpatient, coverage is provided for the following when rendered through an Outpatient Diabetes Education Program:

- visits determined to be Medically Necessary and Appropriate upon the diagnosis of diabetes; and

- subsequent visits under circumstances whereby your physician: (a) identifies or diagnoses a significant change in your symptoms or conditions that necessitates changes in self-management, or (b) identifies, as Medically Necessary and Appropriate, a new medication or therapeutic process relating to the treatment and/or management of diabetes.

The Outpatient Diabetes Education Program is a program of self-management, training and education, including medical nutrition therapy, for the treatment of diabetes. Such program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to the Claims Administrator's criteria acting on behalf of the Program. These criteria are based on the certification programs for outpatient diabetes education developed by the American Diabetes Association (ADA).

Disease State Management

1.67 Through the Disease State Management program, the Claims Administrator identifies those individuals at risk for certain health problems and provides specific courses of care. You may receive assistance in self-management of health problems like diabetes, congestive heart failure or chronic obstructive pulmonary disease. Such services may include:

- an evaluation of your physical and psychosocial status;

- development of an individualized treatment plan by a nurse in conjunction with your physician;

- education and training such as symptom monitoring, medication dosages and compliance, appropriate diet and nutrition, smoking cessation and exercise; and

- ongoing monitoring and treatment modifications.

Weight Loss

1.68

(a) The Program provides coverage for weight reduction programs and surgical treatment for morbid obesity. Eligible procedures will include gastric bypass and gastric restrictive procedures with a Roux-en-Y procedure up to 150 cm, laparoscopic adjustable gastric banding, vertical banded gastroplasty, or biliopancreatic bypass with duodenal switch for the treatment of clinically severe obesity for selected adults (18 years and older) who meet ALL the following criteria:

(1) Body-Mass Index (BMI) of 40 or greater, or BMI of 35 or greater with co-morbid conditions including, but not limited to, life threatening cardio-pulmonary problems (severe sleep apnea, Pickwickian syndrome and obesity related cardiomyopathy), diabetes mellitus, cardiovascular disease or hypertension; and

(2) The patient must have actively participated in non-surgical methods of weight reduction; these efforts must be fully appraised by the physician requesting authorization for surgery; and

(3) The physician requesting authorization for the surgery must confirm the following:

A. the patient's psychiatric profile is such that the patient is able to understand, tolerate and comply with all phases of care and is committed to long-term follow-up requirements; and

B the patient's post-operative expectations have been addressed; and

C. the patient has undergone a preoperative medical consultation and is felt to be an acceptable surgical candidate; and

D. the patient has undergone a preoperative mental health assessment and is felt to be an acceptable candidate; and

E. the patient has received a thorough explanation of the risks, benefits, and uncertainties of the procedure; and

F. the patient's treatment plan includes pre- and post-operative dietary evaluations and nutritional counseling; and

G the patient's treatment plan includes counseling regarding exercise, psychological issues and the availability of supportive resources when needed.

(b) Coverage is also provided for the surgical removal of excess skin (including body contouring or body lifts) when recommended by doctor and performed 2 years following the start of any massive weight loss program.

(c) Prescription drugs for weight loss are covered under the Prescription Drug Program as outlined in paragraph 2.5(b).

Mental Health Services

1.69 The Program covers the services identified in paragraphs 1.70 - 1.75 below that you receive from an Eligible Provider to treat mental illness.

Inpatient Facility Services

1.70 Covered inpatient hospital services provided by a hospital or other Facility Provider, including a Freestanding Gambling Addiction Treatment Facility.

Inpatient Medical Services

1.71 Covered inpatient medical services provided by a Professional Provider:

- individual psychotherapy;
- group psychotherapy;
- psychological testing;
- counseling with family members to assist in your diagnosis and treatment; and
- electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same Professional Provider.

Partial Hospitalization Mental Health Services

1.72 Partial hospitalization for mental health care services provided by a partial hospitalization program which has been approved by the Claims Administrator. Such programs are subject to periodic review by the Claims Administrator.

Outpatient Mental Health Services

1.73 Covered medical services (except room and board) provided by a hospital, or other Facility Provider or Professional Provider when you are an outpatient.

Infertility Counseling, Testing and Treatment

1.74 The Program covers infertility, counseling and treatment. Treatment includes coverage for the correction of a physical or medical problem associated with infertility, diagnostic services and counseling. Assisted fertilization procedures are not covered.

Autistic Disease of Childhood and Attention Deficit Disorders

1.75 The Program provides coverage for the procedures and services required to manage the medical conditions of autistic disease of childhood and attention deficit disorder (ADD/ADHD). These services include, but are not limited to, the diagnostic testing, counseling and ongoing monitoring of medication usage.

Inpatient confinement for environmental change is not covered.

Substance Abuse Services

1.76 The Program covers the services identified in paragraphs 1.77 - 1.80 that you receive in a hospital or other Facility Provider**.**

Inpatient Detoxification

1.77 Up to seven days per admission. The Lifetime Maximum is two admissions**.**

Inpatient Non-Hospital Residential and Rehabilitation Therapy

1.78 Up to 45 days per calendar year. The Lifetime Maximum is two admissions.

Outpatient Rehabilitation

1.79 Up to 50 full session visits or equivalent partial visits per calendar year (10 visits if Out-of-Network). The Lifetime Maximum is 120 visits. A maximum of 30 of these visits may be exchanged on a two-for-one basis to secure up to 15 additional days per calendar year for inpatient non-hospital rehabilitation services beyond the 45-day limit referred to in paragraph 1.76 above. The additional exchange days are subject to the lifetime limits.

1.80 Covered Services also include individual and group counseling and psychotherapy, psychiatric and psychological testing, and family counseling for the treatment of alcohol abuse and drug abuse.

What is Not Covered by Medical Benefits

1.81 ***Benefits are not provided for services, supplies or charges*:**

a. which are not Medically Necessary;

b. which are not prescribed by, performed by or upon the direction of a Professional Provider;

c. rendered by other than hospitals, other Facility Providers, Professional Providers or suppliers as defined in paragraph 1.20 above;

d. which are Experimental/Investigative in nature, as defined in paragraph 1.2(h);

e. rendered prior to your effective date of coverage;

f. incurred after the date of termination of your coverage except as provided herein;

g. for any illness or injury suffered after your effective date as a result of any act of war;

h. for which you would have no legal obligation to pay;

i. received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;

j. for any amounts you are required to pay under the Deductible and/or Coinsurance provisions of Medicare or any Medicare supplement coverage;

k. to the extent payment has been made under Medicare when Medicare is primary; however, this exclusion shall not apply when the Company is obligated by law to offer you all the benefits of this Program and you elect this coverage as primary;

l. for any illness or bodily injury which occurs in the course of employment if benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease or similar type legislation. This exclusion applies whether or not you claim the benefits or compensation;

m. to the extent benefits are provided to members of the armed forces and the National Health Service or to patients in Veteran's Administration facilities for service-connected illness or injury unless you have a legal obligation to pay;

n. for prescription drugs which were paid or are payable under a freestanding prescription drug program;

o. which are submitted by a certified registered nurse and another Professional Provider for the same services performed on the same date for the same patient;

p. rendered by a provider who is a member of your immediate family;

q. for operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise required by law. Other exceptions to this exclusion are: (1) surgery to correct a condition resulting from an accident or disease; and (2) surgery to correct functional impairment which results from a covered disease, injury or congenital birth defect;

r. for telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a Claim form;

s. for personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts or "barrier free" home modifications, whether or not specifically recommended by a Professional Provider;

t. for inpatient admissions primarily for physical therapy;

u. for inpatient admissions primarily for diagnostic studies;

v. for custodial care, domiciliary care, residential care, protective and supportive care including educational services, rest cures and convalescent care;

w. for respite care;

x. dental services other than covered services under 1.36(d) directly related to the care, filling, removal or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, frenectomy, alveolectomy and treatment of periodontal disease, except orthodontic treatment for congenital cleft palates as provided herein;

y. for oral surgery procedures unless specifically provided, except for the treatment of accidental injury to the jaw, sound and natural teeth, mouth or face;

z. non-surgical treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma;

aa. for palliative or cosmetic foot care including flat foot conditions, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes;

bb. for any treatment leading to or in connection with transsexual surgery, except for sickness or injury resulting from such treatment or surgery;

cc. for treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law;

dd. for reversal of sterilization;

ee. for eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or injury);

ff. for the correction of myopia, hyperopia or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants and LASIX;

gg. for nutritional counseling, except as provided herein;

hh. for weight loss programs and drugs, except as provided herein in paragraph 1.68;

ii. for preventive care services, wellness services or programs, except as provided herein or as mandated by law;

jj. physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not Medically Necessary and Appropriate, except as provided herein or as mandated by law;

kk. for treatment of sexual dysfunction not related to organic disease or injury;

ll. for any care for conditions (a) related to hyperkinetic syndromes, learning disabilities, behavioral problems, and mental retardation or (b) for inpatient confinement for environmental change, except that traditional treatment for medical conditions are not excluded;

mm. for therapy services for which no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, and which are determined not to be Medically Necessary and Appropriate;

nn. for immunizations required for foreign travel or employment;

oo. for ambulance services, except as provided herein;

pp. for allergy testing, except as provided herein or as mandated by law;

qq. for well-baby care visits, except as provided herein;

rr. for any other medical or dental service or treatment, except as provided herein or as mandated by law; and

ss. for nicotine cessation support programs and/or classes. Nicotine cessation prescriptions are covered under Section 2 - Prescription Drug Benefits**.**

Care Away From Home

Out-of-Area Care

1.82 The Program also covers care when you are away from home to the extent listed in paragraphs 1.82 - 1.83. If you are traveling and an urgent injury or illness occurs, you should seek treatment from the nearest hospital, emergency room or clinic. If the illness or injury is a Medical Emergency, it will be paid at the In-Network benefit level. If the treatment results in an admission, you have certain responsibilities under Precertification (See paragraph 1.10).

1.83 If the illness or injury is not an emergency and you receive care from an Out-of-Network provider, benefits for covered services will be provided at the lower, Out-of-Network level.

Out-of-Area Coverage for Eligible Dependents

1.84 For a child or spouse who is away from home:

- emergency care will be reimbursed at the higher In-Network level in an emergency situation;

- for non-emergency care, the eligible dependent is required to use Network providers in order to be reimbursed at the higher benefit level; dependents who receive Covered Services from a provider who does not belong to the network will receive the lower level of benefits. If the eligible dependent is in an area where there are no network Providers or an insufficient number of network providers (including specialists), eligible expenses will be reimbursed at the higher benefit level. Student dependents and other family members are encouraged to schedule visits for eligible preventive services, including routine physical examinations, with Network physicians while at home.

Services Provided for a Student While Away at School

1.85 ***For a child who is away at school:***

- emergency care will be reimbursed at the higher In-Network level in an emergency situation; and

- if other medical care is needed and is not provided by the school's medical center, the student is required to use Network providers to receive the higher level of benefits.

The BlueCard Worldwide Program

1.86 The Program provides assistance with medical problems you may incur while traveling outside of the United States. Services include: making referrals and appointments for you with nearby physicians and hospitals; verbal translation from a multilingual service representative; providing assistance if special help is needed; making arrangements for medical evacuation services; processing inpatient hospitalization Claims; and for outpatient or professional services received abroad, you should pay the provider, then complete an international Claim form and send it to the BlueCard Worldwide Service Center. Claim forms can be obtained by calling 1-800-810-BLUE (2583) or the Member Service telephone number on your I.D. card. Claim forms can also be downloaded from www.bcbs.com.

BlueCard PPO Program

1.87 Outlined below in paragraphs 1.88 - 1.92 are specific provisions provided by the Association.

1.88 When you obtain Covered Services through BlueCard outside the geographic area the Claims Administrator serves, the amount you pay for Covered Services is calculated on the lower of:

- the billed charges for Covered Services; or

- the negotiated prices that the on-site Plan ("Host Blue") passes on to the Claims Administrator PPO.

1.89 Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with the health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

1.90 Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular Claim or to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the usual BlueCard method noted above in paragraph 1.88 - 1.92 or require a surcharge, the Claims Administrator

would then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received care.

Benefits After Termination of Coverage

1.91 If you are an inpatient on the day your coverage under this Program terminates, inpatient benefits will be continued until whichever of the following occurs first:

a. the maximum amount of benefits has been paid; or

b. the inpatient stay ends; or

c. you become covered, without limitation as to the condition for which you are receiving inpatient care, under another group program.

1.92 If you are pregnant on the date coverage terminates, no additional coverage will be provided, except as provided in paragraph 1.91.

How to File a Claim

Member Inquiries

1.93 General inquiries regarding your eligibility for coverage and benefits are not Claims. These general inquiries should be made by directly contacting the Member Service Department using the telephone number on your Identification Card.

Authorized Representatives

1.94 You have the right to designate an authorized representative to file or pursue a Claim on your behalf. The Claims Administrator on behalf of the Plan Administrator reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on your behalf. Procedures adopted by the Claims Administrator will, in the case of an Urgent Care Claim, permit a physician or other professional health care provider with knowledge of your medical condition to act as your authorized representative.

Types of Claims

1.95 A Claim is a request for precertification or for the payment or reimbursement of the charges or costs associated with a Covered Service. Claims include:

a. Urgent Care Claim - A Pre-Service Claim which if decided within the time period established for deciding Pre-Service Claims that are not urgent could seriously jeopardize your life, health or ability to regain maximum function, or, 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 requested Covered Service. The Claims Administrator is responsible for determining whether a Claim is an Urgent Care Claim.

b. Pre-Service Claim - A request for precertification or prior approval of an inpatient admission or other Covered Service as described in paragraph 1.10.

c. Post-Service Claim - A request for payment or reimbursement of the charges or costs associated with a Covered Service that you received.

Urgent Care Claims

1.96

a. To file an Urgent Care Claim you must contact Member Services at the telephone number on your Identification Card. The Claims Administrator will make a decision on your Urgent Care Claim as soon as possible following its receipt taking into account the medical exigencies involved. You will receive notice of the decision made on your Urgent Care Claim no later than 72 hours following its receipt.

b. If you do not provide sufficient information with your Urgent Care Claim for the Claims Administrator to determine whether or to what extent benefits are provided under this Section, you will be notified within 24 hours following the Claims Administrator's receipt of the Claim of the specific information needed to complete your Claim. You will be given at least 48 hours from the receipt of the notice to provide the specific information. The Claims Administrator will notify you of its determination on your Claim as soon as possible but not later than 48 hours after the earlier of (1) the Claims Administrator's receipt of the additional specific information, or (2) the date the Claims Administrator informed you it must receive the additional specific information.

c. In addition, the 72 hour time frame may be shortened in those cases where your Urgent Care Claim seeks to extend a previously approved course of treatment and it is made at least 24 hours prior to the expiration of the previously approved course of treatment. In that situation, the Claims Administrator will notify you of its decision concerning your Urgent Care Claim to extend that course of treatment not later than 24 hours following its receipt of the Urgent Care Claim.

Filing and Determination on Non-Urgent Care Pre-Service Claims

1.97 The procedures for filing a Pre-Service Claim with the Claims Administrator are described in paragraph 1.10.

1.98 If your Pre-Service Claim is denied, in whole or in part, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal. For a description of your right to file an appeal concerning an adverse benefit determination of a Pre-Service Claim, see paragraph 1.106.

1.99 You will receive written notice of any decision on a Pre-Service Claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical

circumstances involved. That period of time will not exceed 15 days from the date the Claims Administrator receives the Claim. However, the Claims Administrator may extend this 15 day period one time for an additional 15 days provided the Claims Administrator determines that the additional time is necessary due to matters outside its control, and notifies you of the extension prior to the expiration of the initial 15 day period. If any extension of time is necessary because you did not submit information necessary for the Claims Administrator to make a decision on your Pre-Service Claim, the notice of extension will specifically describe the information you must submit. In this event, you will have at least 45 days from the date the notice of extension is received by you to submit the information before a decision is made on your Pre-Service Claim.

Filing a Post-Service Claim

1.100 If you receive services from a Network provider, you will not have to file a Post-Service Claim. If you receive services from an Out-of-Network provider, you may be required to file the Post-Service Claim yourself, taking the following steps:

a. Know Your Benefits

Review this Section to see if the services you received are Covered Services.

b. Get an Itemized Bill

Itemized bills must include:

- the name and address of the service provider;
- the patient's full name;
- the date of service or supply;
- a description of the service/supply;
- the amount charged;
- the diagnosis or nature of illness;
- for durable medical equipment, the doctor's certification;
- for private duty nursing, the nurse's license number, charge per day and shift worked;
- for ambulance services, the total mileage.

***Note*:** If you've already made payment for the services you received, you must also submit proof of payment (receipt from doctor) with your Claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

c. Copy Itemized Bills

You must submit originals, so you will want to make copies for your records. Once your Claim is received, itemized bills cannot be returned.

d. Complete a Claim Form

Make sure all information is completed properly, and then sign and date the form. Claim forms are available from your employee benefits department or the Claims Administrator's Member Service Department.

e. Attach Itemized Bills to the Claim Form and Mail

Attach all itemized bills to the Claim form and mail everything to the address on the form.

REMEMBER: Multiple services for the same family member can be filed with one Claim form. However, a separate Claim form must be completed for each patient.

Your Explanation of Benefits Statement

1.101 Once a Claim is processed, you will receive an Explanation of Benefits (EOB) Statement. This Statement lists: the provider's charge; allowable amount; the Copayment, Deductible and Coinsurance amounts, if any, you are required to pay; total benefits payable; and the total amount you owe.

1.102 If you believe that the Copayment, Coinsurance or Deductible amount identified in your EOB Statement is not correct or that any portion of these amounts is covered under this Section, you may file a Post-Service Claim with the Claims Administrator. For instructions on how to file such Claims, you should contact the Member Service Department using the telephone number on your Identification Card.

When Post-Service Claims Must Be Filed

1.103 To be eligible for benefits, you must submit all Post-Service Claims by the end of the calendar year following the calendar year containing the date of service.

Determinations on Post-Service Claims

1.104 The Claims Administrator will notify you in writing of its determination on your Post-Service Claim within a reasonable period of time following the Claims Administrator's receipt of your Claim. That period of time will not exceed 30 days from the date your Claim was received. However, this 30 day period of time may be extended one time by the Claims Administrator for an additional 15 days, provided the Claims Administrator determines that the additional time is necessary due to matters outside its control and notifies you of the extension prior to the expiration of the initial 30 day period. If an extension of time is necessary because you did not submit information necessary for the Claims Administrator to make a decision on your Post-Service Claim, the notice of extension will specifically

describe the information you must submit. In this event, you will have at least 45 days from the date the extension notice is received to submit the information before a decision is made on Post-Service Claim.

1.105 If your Post-Service Claim is denied, in whole or in part, you will receive written notification of that denial which will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file an appeal.

Appeal Procedure

1.106 **Complaint and Appeal Procedure**

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

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

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

The Complaint Procedure

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

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

The Appeals Procedure

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

Claims Administrator Appeals

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

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

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

1.107 **Level 1 Appeals**

Level 1 appeals are reviewed by a person who did not make the initial determination and who is not the subordinate of the initial reviewer. If a clinical issue is involved, the Claims Administrator will use a clinical peer for this review unless your appeal concerns an adverse voluntary predetermination decision or unless the adverse decision can be overturned based upon prescreening by a nurse or other qualified reviewer. A clinical peer is a physician or provider who has the same license as the provider who will perform or has performed the service.

If your Level 1 appeal concerns an adverse Pre-Service decision, your appeal may be initiated by letter or over the phone. The Claims Administrator requires its members to submit all other requests for appeal in writing. Written appeal requests, including a detailed description of the problem and all relevant information, should be sent to the entity listed on page 4 of this booklet as the Claims Administrator for Health Benefits to the following address:

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

or to the address (or phone number for adverse Pre-Service or Precertification decisions) provided for filing an appeal on any written notice of an adverse decision that you receive from the Claims Administrator.

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

If you are appealing any other type of adverse decision and sufficient information is available to decide the appeal, the Claims Administrator will resolve your Level 1 appeal within a reasonable period of time but not later than 60 days from receipt of the Level 1 appeal request. If more information is needed to make a decision on your appeal, the Claims Administrator shall send a written request for the information after receipt of the appeal. If the additional information requested is not received within 30 days of the Level 1 appeal request, the Claims Administrator shall conduct its review based upon the available information, which review shall be completed within a reasonable period of time but not later than 60 days from receipt of the Level 1 appeal request. After the Level 1 appeal decision is made, you will be notified within 5 business days in writing by the Claims Administrator of the Plan's decision concerning your Level 1 appeal.

If your Level 1 appeal is denied, your written notice of the denial will contain the specific reasons for the denial, a reference to the specific plan provisions on which the determination is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents relevant to your claim for benefits, a description of the voluntary Level 2 appeal, a statement regarding your right to bring a civil action as described below, and if an internal guideline or protocol was relied on in making the determination, a statement that the guideline or protocol is available upon request free of charge.

1.108 **Level 2 Appeals**

If you are dissatisfied with the Level 1 appeal decision, you may request a Level 2 appeal. At Level 2, the appeal is reviewed by a panel of the Administrator’s staff members. The Claims Administrator may arrange for a hearing at which you may appear. Level 2 appeals concerning adverse Precertification decisions or the denial of any prior approval required by the Plan will be resolved by the panel no later than 30 calendar days from the date your Level 2 appeal request was received by the Administrator. All other Level 2 appeals will be resolved by the panel no later than 45 business days from the date your Level 2 appeal request was received by the Administrator. After the appeal panel makes a decision you will be notified within 5 business days in writing by the Administrator of the Plan's decision concerning your Level 2 appeal.

Expedited Reviews

Any level of appeal can be expedited if:

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

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

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

External Appeals

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

Appeals Filing Time Limit

You are encouraged to file Level 1 appeals on a timely basis. The Claims Administrator will not review a Level 1 appeal if it is received after the end of the calendar year plus 12 months since the incident leading to the Member's appeal. Level 2 appeals must be filed within 60 days of receipt of notice of the Level 1 appeal determination. An External Appeal must be filed within 60 days from receipt of the Plan's Level 2 appeal decision.

Appeals by Members of ERISA Plans

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

1.109 **Nurse On Call**

From My BlueLink page at www.Anthem.com, click on "Nurse On Call" or dial the 24-hour toll free number, 1-888-596-9473 to speak with a specially trained registered nurse. Your call will be kept strictly confidential.

1.110 Nurse On Call addresses your total health care needs rather than focusing on one specific disease, condition or illness through interaction with both the patient and the physician. Nurse On Call promotes the philosophy of shared decision-making by helping you work with your physicians in the task of choosing treatment options that take into account your values and preferences. Nurse On Call provides you with health care support services, including assistance in the self-management of certain health conditions. You have 24-hour access, seven days a week, to health information and personalized support for health decisions.

1.111 **Support services may include:**

a. assessment of your functional and health status, including co-morbidities, risk factors, motivation and confidence in managing your health, and receptivity for change;

b. assessment of your knowledge of your particular condition and your understanding and adherence to the recommendations and instructions of your health care provider;

c. education and training on health-related topics that can be helpful in improving your overall health status, such as appropriate diet and nutrition, smoking cessation and exercise; and

d. ongoing monitoring (coaching) to optimize your health status, ensuring adherence to the physician's treatment plan, identifying and addressing barriers that prevent or hinder adherence to the physician's treatment plan, and assessing the need for case management services.

1.112 You may contact Nurse On Call at the toll-free telephone number listed on your Identification Card.

1.113 **Information About Federal Laws**

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Program provides benefits for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving benefits in connection with a mastectomy, benefits are also provided for the following health services, as you determine appropriate with your attending physician:

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

The amount you must pay for such health services (including copayments and any annual deductible) is the same as required for any other covered health service. Limitations on benefits are the same as for any other covered health service.

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

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

SECTION 2.
PRESCRIPTION DRUG BENEFITS FOR NON-MEDICARE ELIGIBLE INDIVIDUALS
(For you and your dependents)

Introduction

2.0 You and your eligible dependents are covered by the prescription drug program outlined in this Section 2 (the "Prescription Drug Benefits"). The Prescription Drug Benefits under the Program are administered by the Claims Administrator listed on page 4 in the Introduction of this Booklet.

Who Is Eligible?

2.1 Employees enrolled in the Non-Medicare Medical Benefits Section of this Program are covered. Dependents of eligible employees are also covered unless they have prescription drug coverage under another group plan which is the primary plan pursuant to the coordination of benefits provision of this Program. This drug benefit has been designed for individuals who reside in the United States or Puerto Rico.

How Does the Program Work?

2.2 Whenever you or an eligible dependent requires a prescription drug, you have the following options for getting your prescription filled:

a. **Mail Order**

You can order up to a 90-day supply of medications prescribed for treatment of chronic or long-term illness (such as arthritis, diabetes, high blood pressure) through the mail.

b. **Retail Pharmacy**

You can purchase up to a 30-day supply of your prescription medications from any retail pharmacy of your choice. However, there are certain advantages if you obtain your medication from a participating retail pharmacy.

What Is My Cost?

2.3 Prescription drug benefits are provided through an integrated network of national chain and local pharmacies and via mail order from the Claims Administrator's mail pharmacy. Your cost per prescription is displayed below.

	Participating Pharmacy	**Non-Participating Pharmacy**
Retail Prescription Copayments (per Rx)		
Formulary Generic	$10.00	50% copayment
Formulary Brand-Name	$20.00	50% copayment
Non-Formulary Generic or Brand-Name	$30.00	50% copayment
Specialty Drugs – Generic	$0.00	50% copayment
Specialty Drugs – Brand Name	$20.00	50% copayment
Retail, Maximum Supply	Up to 30 days	Up to 30 days
	Participating Pharmacy	**Non-Participating Pharmacy**
Mail Order Prescription Copayment (per Rx)		
Formulary Generic	$20.00	Not Covered
Formulary Brand	$40.00	Not Covered
Non-Formulary Generic or Brand-Name	$60.00	Not Covered
Mail Order, Maximum Supply	Up to 90 days	Not Covered
Specialty Drugs – Generic	$0.00 limited to 30-day supply	50% copayment
Specialty Drugs – Brand Name	$20.00 limited to 30-day supply	50% copayment

Notes: *The copayment for prescriptions which cannot be filled via the mail order service for a 90-day supply due to federal or state law (or their perishable nature) will be prorated based on the length of the prescription and the applicable mail order prescription drug copayment, except for Specialty Drugs. 50% copayment for retail prescription drugs at non-participating pharmacies after submission of paper claims and reimbursement.*

Covered Prescriptions

2.4 The Program covers prescriptions written by licensed physicians for medications which require a prescription pursuant to Federal or State law including insulin, disposable insulin syringes (when dispensed with insulin), blood glucose testing agents and strips. Each prescription for a "controlled substance" (including Schedule II drugs) must be written by a licensed physician on a separate prescription blank.

(a) Prescriptions for smoking cessation drugs such as Zyban, Wellbutrin, and certain nasal sprays are covered when purchased at a local retail pharmacy. Coverage is limited to two courses of treatment per person per lifetime. These medications are not available through the mail service.

(b) Prescription drugs for weight loss are covered for individuals with a BMI >30 without additional risk factors, or BMI >27 with two or more risk factors (such as hypertension, lipid disorders, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and certain cancers).

What Is a Formulary?

2.5 This Program follows a select drug list or formulary. The formulary is an extensive list of Food and Drug Administration ("FDA") approved generic and brand-name prescription drugs selected for their quality, safety and effectiveness. The Program utilizes the Express Scripts Preferred Prescription Formulary list (or the equivalent from another Pharmacy Benefit Manager should there be a change in vendors during the term of the Basic Labor Agreement). The formulary includes products in every major therapeutic category and is maintained by the Claims Administrator. The medications on the formulary have been selected by an independent group of doctors and pharmacists for safety and efficacy, and only FDA approved medications are included. The Claims Administrator may remind your doctor when a formulary medication is available for a medication that is not on your formulary. This may result in a change in your prescription. However, your doctor will always make the final decision on your medication.

2.6 The benefits under this Section include coverage for both formulary and non-formulary drugs. To receive a copy of the formulary, call Member Services at the number on the back of your Identification Card. You can also access the formulary online at the website address listed in the Introduction to this Booklet.

What Prescriptions Are Not Covered?

2.7 Except for insulin, this Program does not cover any drugs or medicines that can be purchased over-the-counter without a prescription, nor does it cover:

- drugs not medically necessary to treat a condition of illness or injury (such as drugs prescribed for cosmetic purposes or nicotine skin patches and nicorette gum), except that the following prescription drugs are covered:

  (1) FDA approved prescriptions for oral contraceptives, and

  (2) Smoking cessation drugs (such as Zyban, Wellbutrin and certain nasal sprays) when purchased at a local retail pharmacy (but not through mail order). Coverage is limited to two courses of treatment per person per lifetime;

- experimental drug

- drugs prescribed for weight loss, except as provided in paragraph 2.5(b);
- growth hormones;
- drugs prescribed for treatment of infertility;
- allergy serums;
- refills of any prescription older than one year; and
- home infusion therapy drugs.

In addition, the following are not available through the mail-order pharmacy:

- drugs for acute, short-term illnesses as determined by the Claims Administrator even though prescribed for 30 days or more; and
- drugs which may not be legally provided through mail service.

Generic Substitution

2.8 A brand-name drug and its generic equivalent must be the same chemically and also have the same therapeutic effect. Generic drugs are also subject to the same rigid FDA standards for quality, strength and purity and are as safe, efficient and effective as brand-name drugs. Although only 30% of all drugs are available generically, generic drugs are usually less costly. Therefore, ask your doctor to authorize generic substitution when an approved generic is available. The Program covers both brand-name and generic equivalent drugs. However, generic equivalents will be substituted where permissible by law.

2.9 If your physician prescribes a brand-name drug that can legally be filled with the generic equivalent and indicates that generic substitution is not permitted, your initial prescription will be filled and the Claims Administrator will send you a form entitled "Explanation for Use of Brand-Name". If your physician determines that a generic equivalent will not be acceptable for your specific need and if you wish to continue using this Program to purchase this particular drug, your physician must complete and return to the Claims Administrator the appropriate form providing the medical reasons a brand-name drug is required. Any subsequent refills and prescriptions authorized by your physician will be filled by the Claims Administrator only if the Claims Administrator determines, on the basis of the physician's explanation, that use of the brand-name drug is required in accordance with accepted standards of medical practice.

Using the Mail Order Option

2.10 ***Initial Prescriptions***

When using the mail service option, it is recommended that you ask your physician to write a prescription for up to a 90-day supply of all needed maintenance drugs, plus the

appropriate number of refills, either prescribing the drug in generic form or agreeing to generic substitution where permitted by law.

- If you or your dependents previously used the mail service and you have a new prescription, follow the instructions outlined on the mail service order form.

- If no one in your family previously ordered prescription drugs through the mail service option, complete the mail service order form and Health Assessment questionnaire which you can obtain by the Claims Administrator or visiting its website (see the Introduction of this Booklet or your ID card for the telephone number and website). Answer all questions, making sure you enter your member identification number in the space provided. This form is completed only with your first order; however, if you become aware of an allergy or health condition after completing the Health Assessment questionnaire, be sure to notify the Claims Administrator. Place your original prescription(s), completed order form, check or money order payable to the Claims Administrator (where applicable) and Health Assessment questionnaire in the pre-addressed envelope also provided by the Claims Administrator and mail to the Claims Administrator.

IMPORTANT: Write your name and member identification number on the back of each prescription you enclose.

Refill Prescriptions

2.11 If the label indicates that the prescription may be refilled and the prescription is not for a Schedule II drug, you may follow one of these refill options:

- Telephone

  Call Member Services toll-free at the number listed on your I.D. card. Have your member identification number, the prescription number and your card information ready.

- Mail

  Use the refill and order form provided with your medication shipment and mail them in the postage-paid envelope along with your copayment.

- Website

  Visit the website listed for the Prescription Drug Benefit Claims Administrator on page 4 of the Introduction to this Booklet. Have your member identification number, the prescription number and your card information ready. You will need to register first before you can refill a prescription.

2.12 If you need medication for an acute short-term illness or injury, and the prescribed medication is FDA approved only for short-term use, it cannot be obtained through the mail service. You must obtain medication prescribed for less than a 30-day period from a

retail pharmacy under the Retail Pharmacy option (preferably a participating network pharmacy).

2.13 If you need medication immediately for a chronic or long-term condition, have your doctor write two prescriptions: one for a two-week supply, that you can have filled at a retail pharmacy, and one for up to a 90-day supply that you can send to the mail service program. Remember, the initial prescription for a drug ordered through the mail-service will be limited to a 30-day supply.

How Soon Will I Receive My Mail Order Prescription?

2.14 Orders are usually processed and mailed within 48 hours of receipt via First Class U.S. Mail or United Parcel Service. However, you should allow from 7 to 11 days from the date you mailed your prescription for normal mail delivery.

Using the Retail Pharmacy Option

2.15 When using the Retail Pharmacy option, it is recommended that you ask your physician to write the prescription for up to a 30-day supply and to prescribe the drug in generic form or agree to generic substitution. On average, a brand-name drug costs twice as much as its generic equivalent.

Participating Pharmacies

2.16

a. At a participating retail pharmacy, show your Identification Card and pay the following copayments:

Retail Prescription Copayments (per Rx)	**Participating Pharmacy**
Formulary Generic	$10.00
Formulary Brand-Name	$20.00
Non-Formulary (Generic or Brand-Name)	$30.00
Specialty Drugs – Generic	$0.00
Specialty Drugs – Brand Name	$20.00

b. Participating pharmacies currently include national chains such as Albertsons, CVS, Fagen, Giant Eagle, Rite Aid, Sav-on, Walgreens, Wal-Mart, and Winn Dixie as well as selected local drugstores. To find a participating retail pharmacy nearest you, call Member Services at the number listed on your I.D. card and use the voice-activated pharmacy locator system or visit the website at the address listed for the Prescription Drug Benefits Claims Administrator in the Introduction to this Booklet.

c. There are several advantages to using a Participating Retail Pharmacy. All participating retail pharmacies maintain computerized files on all medications you and your family members obtain, thereby reducing your risk of an adverse drug

reaction if you are taking more than one prescription or have special medical conditions. You obtain your medication by presenting your Identification Card and paying your share of the discounted price. No claim forms are required when you use a participating retail pharmacy. However, if you obtain medication from a pharmacy that is not a participating retail pharmacy, you must pay the pharmacy its charge, complete a claim form (you and the pharmacist), attach your receipts, and send the claim to the Claims Administrator (within one year of purchase) for reimbursement.

Non-Participating Retail Pharmacies

2.17 At a non-participating retail pharmacy, pay the pharmacy its charge for the medication. Then complete your portion of the Claim Form, which may be obtained by visiting the Claims Administrator's website listed in the Introduction to this Booklet or by calling the Claims Administrator at the telephone number on your I.D. card. Have the pharmacist complete the pharmacy portion of the Form (including the NDC number), attach a receipt for each prescription and send to the Claims Administrator at the address shown on the Form **within one year** from the purchase date. Claims submitted without all required information will be returned for proper completion, which will delay your reimbursement. Claims filed later than one year after purchase are not eligible for reimbursement. A separate Form must be completed for each family member and each pharmacy. You will be reimbursed 50% of the pharmacy's charge for each properly completed claim filed on a timely basis. A new Form will be sent to you with your reimbursement check.

Before Leaving the Doctor's Office

2.18 It is recommended that before you leave the doctor's office, you examine the prescription to make sure that generic substitution is permitted. Also make sure that the prescription includes the date, patient's name and doctor's name and signature.

What Are the Quality Standards?

2.19 All prescriptions dispensed by the mail service option or at a participating retail pharmacy under the Retail Pharmacy option meet the highest pharmaceutical standards of quality, safety and effectiveness. Each prescription will be filled by qualified licensed pharmacists and checked to assure that the quantity, quality and potency are accurate. Also, under the drug utilization review program, prescriptions filled are examined for potential drug interactions based on your personal medication profile. A drug interaction occurs when certain drugs acting together result in an adverse effect on the body. The drug utilization review is especially important if you or your covered dependent(s) take many different medications or see more than one doctor. If there is a question about your prescription, your pharmacist may contact your doctor before dispensing the medication.

Who Do I Contact for Express Scripts By Mail and Pharmaceutical Information?

2.20 If you have any questions or problems concerning a prescription ordered via the mail service program, call Member Services at the number listed on your I.D. card and use the

automated system or visit the website listed for the Prescription Drug Benefit Claims Administrator in the Introduction to this Booklet. If you do not receive your medication in 14 days, call the Claims Administrator and a replacement order will be sent to you at no additional charge if your first order cannot be traced. The toll-free telephone number listed on your I.D. card is also available for any questions about an order, including physician inquiries, and for you to phone in refills.

Deadlines for Initial Determinations

Post-Service Claims

2.21 A Post-Service Claim is any claim for a benefit that is made after the prescription is received. You will receive notice of the decision that has been made on your Post-Service Claim within 30 days of the Claims Administrator's receipt of the claim. A 15 day extension is available. To be eligible for benefits under the Program, your claim must be submitted to the Claims Administrator within one year from the prescription purchase date. Claims other than Post-Service Claims will be decided within the timeframes described beginning in Section 1.99.

How Do I Appeal a Claim for a Prescription Purchased At a Retail Pharmacy or Through Mail Order?

2.22 If you want to appeal the denial of a prescription claim under this Section you may do so by using the following procedures.

The appeal procedure involves the following steps:

a. Initial Review by the Claims Administrator

b. Second Review by the Claims Administrator

Initial Review by Claims Administrator

2.23

a. If you receive notification that a claim has been denied by the Claims Administrator, in whole or in part, you may appeal the decision to the Claims Administrator at the address listed for the prescription drug benefits Claims Administrator in the Introduction of this Booklet. Your appeal must be in writing and must be submitted not later than 180 days from the date you received notice of the adverse benefit determination.

b. Upon request to the Claims Administrator, you may review all documents, records and other information relevant to the claim which is the subject of your appeal and you shall have the right to submit any written comments, documents, records, information, data or other material in support of your appeal.

c. The Claims Administrator will provide written notification of its decision within a reasonable period of time not to exceed 30 days following receipt of the appeal by the Claims Administrator.

d. A notification of an adverse benefit determination on your appeal will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to file a further appeal as outlined in paragraph 2.25. The following additional information will be included in the notification, if applicable:

(1) Any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination will be set forth;

(2) An explanation of any scientific or clinical judgment forming the basis for the conclusion that a prescription was not covered.

e. The decision of the Claims Administrator on appeal is final unless you file a second appeal with the Claims Administrator.

Second Review by the Claims Administrator

2.24

a. You may further appeal the claim within 60 days of your receipt of an adverse determination by writing to the Claims Administrator at the address listed in the Introduction to this Booklet for the Prescription Drug Benefits Claims Administrator. Once again, you should supply any information necessary to support your position. You will be advised of the final decision within 30 days of the date that your appeal is received.

b. Notification of an adverse benefit determination by the Claims Administrator will include, among other items, the specific reason or reasons for the adverse benefit determination and a statement describing your right to take legal action for your benefit pursuant to Section 502(a) of ERISA with 90 days of receiving the denial.

c. If you do not take legal action for your benefit within 90 days of your receipt of the denial, the decision of the Claims Administrator on appeal is final and binding.

SECTION 3.
MEDICAL AND PRESCRIPTION DRUG BENEFITS FOR MEDICARE ELIGIBLE INDIVDUALS (For you and your Medicare eligible dependents)

Introduction: Medicare Advantage Plan

3.0 Plan will include a Non Part D Rider (to ensure coverage of ED drugs, folic acid, etc.) in addition to covering all Part D designated medications.

The MAPD Plan will offer an Incentive Formulary.

Incorporate P1 Pharmacy Network – This network allows members to obtain a generic prescription at a preferred pharmacy for a copayment of $8, while generic prescriptions at non-preferred pharmacies are available for a copayment of $10.

The company will not prevent Participants in the MAPD plan to obtain a 90-day prescription at a retail store for 2x retail copayments, provided the MAPD plan carrier is willing to offer that benefit at no additional cost. It is understood that this is not a negotiated benefit, nor will it be considered a negotiated benefit.

Schedule of Benefits

3.1

	Non-Differential
Description	**In-Network/Out-of-Network Services**
Annual Medical Deductible	None
Is Annual Medical Deductible combined for IN and OUT of Network?	N/A
Annual Medical Out-of-Pocket Maximum	$1,250
Is Annual Medical Out-of-Pocket Maximum combined for IN and OUT of network?	Yes
PHYSICIAN SERVICES Primary Care Physician Office Visit (includes Non-MD office visits)	$10 copay
Specialist Office Visit	$20 copay
INPATIENT SERVICES Inpatient Hospital Stay Benefit Period in days. (A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.)	Unlimited

Inpatient Hospital Stay	10% Per Admit
Skilled Nursing Facility Care - prior hospital stay requirement waived?	Yes
Skilled Nursing Facility Care - Benefit Period (In days)	Unlimited
Skilled Nursing Facility Care	$0 days 1-20, 10% after
Inpatient Mental Health Lifetime Maximum number of days	Unlimited

Inpatient Mental Health in a Psychiatric Hospital	10% Per Admit
OUTPATIENT SERVICES Outpatient Surgery	10%
Outpatient Hospital Services	10%
Outpatient Mental Health/Substance Abuse (Individual Visit)	$20 copay
Outpatient Mental Health/Substance Abuse (Group Visit)	$20 copay
Partial Hospitalization (Mental Health Day Treatment) per day	$20 copay
Comprehensive Outpatient Rehabilitation Facility(CORF)	$20 copay
Occupational Therapy	$20 copay
Physical Therapy and Speech/Language Therapy	$20 copay
Cardiac/Pulmonary Rehabilitation	$20 copay
Kidney Dialysis	10%
MEDICARE-COVERED SPECIALIST VISITS Chiropractic Visit (Medicare-covered)	$20 copay
Podiatry Visit (Medicare-covered)	$10 copay
Routine foot care – Number of Visits Per Year	Up to 12
Eye Exam (Medicare-covered)	$10 *PCP / $20 *SPC
Hearing Exam (Medicare-covered)	$10 *PCP / $20 *SPC
Dental Services (Medicare-covered)	$10 *PCP / $20 *SPC
AMBULANCE/EMERGENCY ROOM/URGENT CARE Ambulance Services	10%
Ambulance Copay Waived if Admitted?	No
Emergency Room (Includes Worldwide Coverage)	$40 copay
Emergency Room Copay Waived if Admitted within 72 hours?	Yes
Urgently Needed Care (Includes Worldwide Coverage)	$40 copay
Urgent Care Copay Waived if Admitted within 72 hours?	Yes
PART B DRUGS AND BLOOD Part B Drugs include - Immunosuppressive, Anti-nausea, Inhalation Solutions, Hemophilia Clotting Factors, Antigens, Outpatient Injectable Medications Administered in a Physician's Office	$20 copay
Chemotherapy Drugs	$20 copay
Blood	$0 copay
Blood 3 pint deductible waived?	Not Applicable
DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES Durable Medical Equipment	10%
Prosthetics	10%
Orthotics	10%

Diabetic Shoes and Inserts	$0 copay
Medical Supplies	10%
Diabetes Monitoring Supplies	$0
HOME HEALTHCARE AGENCY & HOSPICE Home Health Services	$0
Hospice (Medicare-covered)	$0
*PCP = Primary Care, *SPC = Specialty Care	
PROCEDURES Clinical/Diagnostic Lab Test	$0 copay
Outpatient X-ray Services	10%
Complex Diagnostic Procedure/Test (includes non-radiological diagnostic services)	10%
Diagnostic Radiology Service	10%
Radiation Therapy Treatment	$20 copay
PREVENTIVE SERVICES (MEDICARE-COVERED) Cardiovascular Screenings	$0
Immunizations (Flu, Pneumococcal, Hepatitis B Vaccines)	$0
Pap Smears and Pelvic Exams	$0
Prostate Cancer Screening	$0
Colorectal Cancer Screenings	$0
Bone Mass Measurement (Bone Density)	$0
Mammography Screening	$0
Diabetes - Self-Management Training	$0
Medical Nutrition Therapy and Counseling	$0
Annual Wellness Exam and One-time Welcome-to-Medicare Exam	$0
Smoking Cessation Visit	$0
Abdominal Aortic Aneurysm (AAA) Screenings	$0
Diabetes Screening	$0
HIV Screening	$0
Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse	$0
Screening for Depression in Adults	$0
Screening for Sexually Transmitted Infections	$0
High Intensity Behavioral Counseling to Prevents STIs and Intensive Behavioral Therapy for Cardiovascular Disease	$0
Screening and Counseling for Obesity	$0
Glaucoma Screening	$0
Kidney Disease Education	$0
Self-Dialysis Training	$10 copay
Hepatitis C Screening	$0
ADDITIONAL BENEFITS/PROGRAMS (Non Medicare-covered)	

Routine Dental Services – oral evaluation – one every 12 months Cleanings – one every 6 months X-rays – full mouth, panoramic, one every 12 months	IN-Network Oral Evaluation, cleanings and X-rays $0 copay per visit Out-of-Network Oral Evaluation, cleanings and X-rays 30% coinsurance
Routine Eye Exam Refraction - every calendar year	$0
Routine Vision Eyewear (Eyeglasses or contact lenses) Eyeglass Frames: One pair of eyeglass frames, once every two calendar years* Eyeglass Lenses (in lieu of contact lenses): One pair of standard plastic prescription lenses, once every two calendar years Standard single vision lenses Standard bifocal lenses Standard trifocal lenses Standard lenticular lenses Contact Lenses* (in lieu of eyeglass lenses): Once every two calendar years Elective conventional lenses (nondisposable) OR Elective disposable lenses OR Non-elective contact lenses * Any remaining unused eyewear benefit amount must be used in the same calendar year of the first eyewear purchase. Unused amounts cannot carry over to the following calendar year or benefit period.	IN-Network Must use a Blue View Vision provider. $0 copay for routine vision exams $100 allowance towards the purchase of frames $0 copay for eyeglass lenses $100 allowance towards the purchase of elective contact lenses Non-elective contact lenses covered in full After the plan pays benefits for routine vision exams and eyewear; you are responsible for any remaining cost. Out-of-Network Up to $100 reimbursement for routine vision exams Up to $100 reimbursement towards the purchase of frames Up to $100 reimbursement on Single vision lenses Up to $110 reimbursement on Bifocal lenses Up to $120 reimbursement on Trifocal lenses Up to $130 reimbursement on Lenticular lenses Up to $100 reimbursement towards the purchase of elective contact lenses Up to $210 reimbursement towards the purchase of nonelective contact lenses After the plan pays benefits for routine vision exams and eyewear, you are responsible for any

	remaining cost.
Routine Hearing Exam for Hearing Aids Routine hearing exams are limited to one every calendar year Hearing aid fitting evaluations are limited to one per covered hearing aid Routine hearing exams and fitting evaluations are limited to a $70 maximum benefit every calendar year combined in-network and out-of-network.	In-Network Must use a Hearing Care Solutions participating provider. $0 copay for routine hearing exams Out-of-Network $0 copay for routine hearing exams
Hearing Aid Allowance Hearing aids are limited to a $1,700 benefit per ear with a maximum benefit of $3,400 every three calendar years. The maximum benefit coverage amount applies to covered, prescribed hearing aids. Includes digital hearing aid technology and inner ear, outer ear, and over the ear models. Fitting adjustment after hearing aid is received, if necessary. The hearing aid benefit does not provide coverage for amplifiers, internet purchases, assistive listening devices (ALDs), ear molds or accessories. For additional benefit information and to locate a Hearing Care Solutions participating provider, please contact Member Services. You will be directed to the dedicated Hearing Care Solutions Member Services line. Hearing benefit management administered by Hearing Care Solutions, an independent company. Members receive a free battery supply during the first three years with a 64-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid fitting evaluations, you are responsible for any remaining cost.	In-Network Must use a Hearing Care Solutions participating provider. $0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids Out-of-Network $0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids
Benefit per ear or combined	Per ear
Hearing Aid period	Every three calendar years
Annual Routine Physical Exam	$0
WELLNESS/CLINICAL PROGRAMS NurseLine	Included
Fitness	SilverSneakers
Congestive heart failure (CHF) care management	Included
Coronary Artery Disease (CAD) care management	Included
Chronic Obstructive Pulmonary Disease (COPD) care management	Included
Cancer care management	Included
Chronic care programs	Included
Diabetes care management	Included
Other care management programs (fall risk management and care transitions into our care management activities	Included
Palliative Care Services	Included

SpecialOffers@Anthem	Included
Heart Disease care management	
House calls Program	Included
Outpatient Prescription Drug Coverage	
Prescription Drug Plan	Custom Plan
Part D Gap Coverage	Full Gap Coverage
Formulary	Enhanced
Bonus Drug List	Standard List U with 6 ED per 30 day period
Formulary Edits (step therapy, quantity limits, prior authorization)	Standard: Edits On
Rx Deductible	None
Part D Retail Copay (up to a 30-day supply)	**Preferred Network**
Select Generics Tier 1: Generic	$0 $8
Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	$15 $45
Tier 4: Specialty Tier	$50
Part D Retail Copay - up to a 30-day supply	**Standard Network**
Select Generics Tier 1: Generic	$0 $10
Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	$15 $45
Tier 4: Specialty Tier	$50
Part D Retail Copay - up to a 90-day supply (many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will only need to pay two copays.)	**Preferred Network**
Select Generics Tier 1: Generic	$0 $16
Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	$30 $90
Part D Retail Copay - up to a 90-day supply (many of our retail pharmacies can dispense more than a 30-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will only need to pay two copays.)	**Standard Network**
Select Generics Tier 1: Generic	$0 $20
Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	$30 $90
Part D Preferred Mail Order Copay - up to a 90-day supply (Specialty limited to a 30-day supply; 30-day Retail copay or coinsurance applies)	

Select Generics Tier 1: Generic Tier 2: Preferred Brand	$0 $16 $30
Tier 3: Non-Preferred Brand Tier 4: Specialty Tier	$90 $50
Initial Coverage Limit	$4660
TrOOP Threshold	$7400
Catastrophic Coverage over TrOOP (greater amount of)	Custom
Copay for generics	$10
Copay for all other drugs	$10
OR Coinsurance	N/A
2023 SNF is capped at $20 for days 1-20 and $196 for days 21+	

Claim Procedures

3.2 The following definitions have special meaning when used in this Plan in accordance with claim procedures.

- A "Claim" is any request for a Plan benefit or benefits made by you or your authorized representative in accordance with the Plan's procedures for filing benefit claims.
- A "Pre-Service Claim" means any claim for a benefit with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.
- A "Post-Service Claim" is a claim for a benefit that is not a pre-service claim within the meaning of the language quoted in the pre-service definition, above.
- An "Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Requests for determinations of eligibility or general inquiries to the availability of particular Plan benefits or the circumstances under which benefits might be paid under the terms of the Plan will not be treated as a claim for benefits for the purposes of the Claim Procedures.

Initial Benefit Determination

- If you file a Claim in accordance with the provisions of the Plan, you will receive an Explanation of Benefits (EOB) from the third party administrator that will tell you if your Claim has been paid or denied, or if additional information is

needed to process your Claim. If additional information is requested, it is your responsibility to provide it, along with a copy of the EOB, to the third party administrator, so that your Claim can be processed with the additional information. If your Claim is denied, the EOB will tell you the reason for the denial and how you can have the decision reviewed.

- Under normal circumstances a decision on your Claim for benefits will be made within 30 days after receipt of your properly filed Claim with the appropriate third party administrator. However, if your Claim for benefits is for one involving Urgent Care, a decision on such Claim will be rendered within 24 hours after receipt. Or, if your Claim is for a Pre-Service Claim, a decision will be provided within 15 days after receipt. These periods may be extended, however, one time by the third party administrator for up to 24 hours for Urgent Care Claims and 15 days for all others, provided that the administrator determines that such an extension is necessary due to matters beyond their control and notifies you, prior to the expiration of the initial notification periods, of the circumstances requiring the extension of time and the date by which the administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and you shall be afforded at least 48 hours for Urgent Claims and 45 days for all others from receipt of the notice within which to provide the specified information.
- In the event you or your authorized representative does not follow the Plan's filing procedures for a Pre-Service Claim, the Plan will provide notification to you or your authorized representative accordingly. For all Pre-Service Claims, the Plan must notify you or your authorized representative, of failure to follow filing procedures within 5 calendar days (24 hours in the case of a failure to follow filing procedures for an Urgent Care Claim). Notification by the Plan may be oral unless written notification is requested by you or your authorized representative. The notification of failure to follow filing procedures for Pre-Service Claims will apply only when a communication is received from you or the health care professional representing you that specifies the identity of the Covered Person, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested, and the communication is received by the third party administrator.
- If your Claim for benefits is wholly or partially denied, the appropriate third party administrator will notify you in writing. This written notice will tell you the reason for the denial, the provisions of the Plan on which the denial is based, and what additional information is needed, if any, that could change the decision. If a standard claim processing protocol was followed, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to you free of charge upon written request. If the determination is based on medical necessity or similar exclusion or limit, then the notice will state that an explanation of the clinical judgement used and how the terms of the Plan were applied to your medical circumstances will be provided free of charge upon

written request. The notice will also tell you how you can have the decision reviewed.

- Any decision by the Plan to terminate or reduce benefits that have already been granted with the potential of causing disruption to ongoing care, course of treatment, number of treatments or treatments provided as a covered health service before the end of such treatments shall constitute a denied claim. The Plan will provide you with notice of the denial at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated. The written notice of denial will contain the information outlined above.
- Any Urgent Care Claim requesting to extend a course of treatment beyond the initially prescribed period of time, or number of treatments, must be decided within 24 hours provided that the Claim is made at least 24 hours prior to the expiration of the initially prescribed period. Notification will be provided in accordance with the Urgent Care Claim notice requirements.

Claim Review Process

- If you receive a written notice denying your Claim for benefits, in whole or in-part, and you do not agree with such determination, you can have your Claim reviewed. If you want your Claim reviewed, you, or your authorized representative, must file a written request for review with the appropriate party within 180 days after you received the written notice of denial of your Claim for benefits.
- This review provision will allow you to request from the Plan a review of any Claim for benefits. Such request must include the employee/retiree name and social security number, and name of the patient. The request for review must be in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the Claim. Submit written comments, documents, records, and other information relating to the Claim. This review provision will also allow you to request, free of charge, reasonable access to documents, records, and other information relevant to your Claim. A document, record or other information is considered relevant if it was relied on in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination; demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
- In the case of Urgent Care Claims, a request for an expedited review may be submitted orally and all necessary information, including the Plan's benefit

determination upon review, may be transmitted between the Plan and you via telephone, facsimile, or other available similarly expeditious methods. If the benefit determination is transmitted orally, a written notification will be furnished within 3 days after the oral notification.

- The review of the denial will be made by an appropriate named fiduciary that is neither the party who made the initial Claim determination nor the subordinate of such party. The review will not defer to the initial Claim determination and will take into account all comments, documents, records and other information submitted by you without regard to whether such information was previously submitted or relied upon in the initial determination. In upholding any denied Claim that is appealed, which denial is based in whole or in part on a medical judgment, an appropriately qualified health care professional who is neither an individual who was consulted in connection with the denied Claim that is the subject of the appeal nor the subordinate of any such individual shall be consulted.
- Under normal circumstances, you will be notified of a decision on your request for review within 30 days after receipt. However, if your request for review is for a Claim involving Urgent Care, a decision on your request for review will be rendered within 72 hours after receipt of your request. Or, if your request for review is for a Pre-Service Claim, a decision on your request for such a review will be provided within 15 days after receipt of your request. In all cases, you will be provided with written notification of the determination on review. If your Claim is denied, you will be told the reason for the denial, the provisions of the Plan on which the denial is based, the documents and information you can receive upon request, and what additional information is needed, if any,that could change the decision. If a standard claim processing protocol was followed, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to you free of charge upon request. If the determination is based on medical necessity or similar exclusion or limit, then the notice will state that an explanation of the clinical judgment and how the terms of the plan were applied to your medical circumstances will be provided free of charge upon written request. The notice will tell you of your right to bring a civil action under section 502(a) of the Act following a final adverse benefit determination on review. The notice will also tell you how you can appeal the decision to the Plan Administrator.

Appeal Process

- If you want to appeal (in whole or in part) the decision made on your request for review, you, or your authorized representative, must file a written appeal with the Plan Administrator within 180 days after you received the written notice of denial of your request for review of your Claim. This review provision will allow you to request from the Plan a review of any Claim for benefits. Such request must include the employee/retiree name and social security number, and name of the patient. The request for review must be in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the Claim. Submit written comments, documents, records, and other information relating to the Claim. This appeal provision will also allow you to request, free of charge, reasonable access to documents, records, and

other information relevant to your Claim. A document, record or other information is considered relevant if it was relied on in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied on in making the benefit determination; demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination; or constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

- In the case of Urgent Care Claims, a request for an expedited review may be submitted orally and all necessary information, including the Plan's benefit determination upon review, may be transmitted between the Plan and you via telephone, facsimile, or other available similarly expeditious methods. If the Plan Administrator's determination is transmitted orally, a written notification will be furnished within 3 days after the oral notification.
- The Plan Administrator will make the appeal determination. The appeal determination will not defer to the initial Claim determination or the determination on review and will take into account all comments, documents, records and other information submitted by you without regard to whether such information was previously submitted or relied upon in the initial determination or the request for review. In upholding any denied request for review that is appealed, which denial is based in whole or in part on a medical judgment, an appropriately qualified health care professional who is neither an individual who was consulted in connection with the denied request for review that is the subject of the appeal nor the subordinate of any such individual shall be consulted.
- Under normal circumstances, the Plan Administrator will render a decision on your appeal within 30 days after receipt of your appeal. However, if your request for appeal is for a Claim involving Urgent Care, the Plan Administrator will render a decision on your request for appeal within 72 hours after receipt of your appeal.
- Or, if your request for appeal is for a Pre-Service Claim, a decision on your request for such appeal will be provided within 15 days after receipt of your appeal. In all cases, the Plan Administrator will provide you with written notification of the determination on appeal. If your appeal is denied in whole or in part, you will be told the reason for the denial, the provisions of the Plan on which the denial is based, the documents and information you can receive upon request. If a standard claim processing protocol was followed, then the notice will state that a protocol was relied upon and that a copy of such protocol is available to you free of charge upon request. If the determination is based on medical necessity or similar exclusion or limit, then the notice will state that an explanation of the clinical judgment and how the terms of the plan were applied to the claimant's medical circumstances will be provided free of charge upon written request, including the names of any medical professionals consulted during the review process. The notice will also tell you of your right to bring a

civil action under section 502(a) of the Act following a final adverse benefit determination on review.

- If you feel the Plan has not complied with the established Plan Claim Procedures, there are steps you can take to enforce your rights. For additional information, please refer to the ERISA section of this Plan.

Limitation

- No action at law or in equity can be brought to recover on this Plan until the appeals procedure has been exhausted as described in this Plan.
- No action at law or in equity can be brought to recover after the expiration of two (2) years after the time when written proof of loss is required to be furnished to the Plan Administrator.

SECTION 4.
GENERAL PROVISIONS

Eligibility

4.0 You will be eligible to participate in this Program if you:

a. retire under the Company pension plan on or after September 1, 2004 on other than a deferred vested pension from a group of employees designated by the Company as covered by this Program and at the time of retirement have 15 or more years of continuous service, or

b. are receiving a Surviving Spouse's benefit under the Company pension plan as the Surviving Spouse of an employee

(1) who retires under the Company pension plan on or after September 1, 2004 on other than a deferred vested pension from a group of employees designated by the Company as covered by this Program, and dies thereafter, or

(2) who dies on or after September 1, 2004 at a time when the employee is accruing continuous service in a group of employees designated by the Company as covered by this Program;

provided, however, that you:

(i) are not insured under any other group insurance plan or program providing hospital and medical coverage, including a prepaid group practice plan or Health Maintenance Organization, toward the cost of which the Company contributes; and

(ii) are a resident of the United States or Puerto Rico.

4.1 You will be eligible for benefits under this Program if you:

a. elect coverage under the Program of Hospital-Medical Benefits when you first become eligible for such coverage; however, if you and/or your dependents are eligible for medical coverage under any other employer's insurance program, you may defer electing coverage under Section 1 for yourself and your dependents until the other coverage terminates, provided you notify the Company (see paragraph 4.11) within 30 days of the termination of the other coverage; and

b you authorize deduction of premiums for such coverage from your pension or Surviving Spouse's Benefit or, in the event your pension or benefit is insufficient to cover the premium, send a check or money order payable to the Company each quarter in an amount equal to three times the monthly cost applicable to you in accordance with paragraph 4.2; such payment is to be mailed to the Company and

must be received no later than the 10th day of the calendar quarter for which payment is due (i.e., January 10, April 10, July 10, October 10).

Retiree Monthly Cost

4.2 The Total Cost of Coverage is determined by reviewing historical Medical and Prescription Drug Benefits claims experience for covered participants, adjusting to current benefits levels if applicable, and projecting claims experience forward to future years by applying an assumed annual health care cost trend rate. This trend rate is determined by the Company's actuary considering survey data on expected health care cost trends of other large employers to capture evolving marketplace trends that are driving levels of future Medical Benefits costs, as well as by considering historical claims experience of retired plan participants.

The Total Cost of Coverage is determined separately for Non-Medicare retirees and spouses, and Medicare-eligible retirees and spouses, to capture the effect of Medicare reimbursements on Medical Benefits plan costs for Medicare-eligible retirees and spouses. The Total Cost of Coverage is also determined separately for Minnesota and Michigan

retirees and spouses to capture any potential differences in provider costs between those two states.

The Total Cost of Coverage is reduced for any pharmacy rebates provided to Cliffs by the pharmacy benefit manager, as well as any Retiree Drug Subsidy (RDS) payments for which the Company is eligible and receives for Medicare-eligible retirees.

The Total Cost of Coverage will include administrative costs borne by the Company to operate the Medical Benefits Plan including, but not limited to, fees charged by medical plan administrators and pharmacy benefit managers.

The Company and retirees will share in the Total Cost of Coverage using the following percentage splits.

a. Non-Medicare Participants Pre-04: Retirees will pay 35% of the Total Cost of Coverage, not to exceed a 10% increase in the rates charged to the retirees over the prior year.

b. Medicare Participants Pre-04: Retirees will pay 40% of the Total Cost of Coverage, not to exceed a 10% increase in the rates charged to the retirees over the prior year.

c. Non-Medicare Participants Post-04: Subject to Section 4.3, retirees will pay 39.5% of the Total Cost of Coverage, not to exceed a 10% increase in the rates charged to the retirees over the prior year.

d. Medicare Participants Post-04: Subject to Section 4.3, retirees will pay 43% of the Total Cost of Coverage, not to exceed a 10% increase in the rates charged to the retirees over the prior year.

e. Surviving spouses are not required to pay the cost-shares described above. Medicare eligible Surviving Spouses will pay $30 per month and Non-Medicare eligible Surviving Spouses will pay $75 per month.

Notwithstanding the above, effective January 1, 2023 and for the term of the Pensioners' and Surviving Spouses' Health Insurance Agreement, the monthly participant rates will be:

Monthly Rates
Non-Medicare Eligible Participants

Calendar Year	Full Coverage
2023	$257
2024	$257
2025	$257
2026	$257

Effective January 1, 2027, these rates will increase pursuant to the methodology provided above in this Section 4.2.

Note: Monthly rates are established on a per person basis and include coverage for eligible dependent children, if any. Notification of annual rates will be given annually to those enrolled in retiree medical coverage.

4.3 For retirees who retire on or after January 1, 2015, a formula was negotiated in 2012 to establish a Per Capita Maximum on the amount of contributions that the Company shall be required to make for each Pensioner, and spouse of a Pensioner.

Based on the formula, the Per Capita Maximums were determined to be the following, which shall apply moving forward:

Medicare eligible retirees and spouses	$203 per month
Non-Medicare eligible retirees and spouses who retired from a Michigan-based operation	$503 per month
Non-Medicare eligible retirees and spouses who retired from a Minnesota-based operation	$732 per month

The Per Capita Maximums shall not apply to Surviving Spouses.

4.4 If you or your spouse is totally disabled when major medical coverage terminates under the Program of Insurance Benefits for active employees, the cost of Hospital and Physicians' Services, Major Medical Benefits, and Prescription Drug Benefits coverages under the Program for such disabled person will be paid by the Company for any portion of the 18-month period immediately following termination of coverage under the Program of Insurance Benefits during which you are enrolled under the Program and you or your spouse continues to be totally disabled.

Definition of Dependents

4.5 The term "dependents" includes only:

a. The spouse of a pensioner.

b. Unmarried children under 19 years of age. Such children include:

(1) Natural-born children,

(2) Stepchildren,

(3) Legally adopted children (including children who have been placed with you for adoption),

(4) Dependents who become eligible due to a Qualified Medical Child Support Order (QMCSO), and

(5) Children for whom you have court-appointed guardianship.

c. Children after attainment of age 19 but not beyond attainment of age 25, if, in addition to otherwise meeting the definition of dependent children as contained in (b), such child is a full-time student (see paragraph 4.39through 4.42).

d. Children after attainment of age 19, if, in addition to otherwise meeting the definition of dependent children as contained in (b), such child is incapable of self-support because of a disabling illness or injury that commenced prior to age 19 (see paragraphs 4.43 and 4.44).

e. Children after attainment of age 19, if, in addition to otherwise meeting the definition of dependent children as contained in (b), such child is incapable of self-support because of a disabling illness or injury that commenced prior to age 19 while covered as a full-time student (see paragraphs 4.39 through 4.42). In such cases, coverage will continue until the earlier of such individual's eligibility for Medicare or attainment of age 25.

You may obtain without charge a copy of the Program's QMCSO procedures from the Plan Administrator.

4.6 To be eligible for dependent coverage, proof may be required that the dependent meets the requirements stated above. Special certification will be required to qualify dependents under paragraph 4.5(c), (d) and (e).

4.7 The term dependents does not include any person who:

a. is covered under any other group insurance plan or program providing hospital and medical coverage, including a prepaid group practice plan or Health Maintenance Organization, toward the cost of which the Company contributes,

b. is covered as a pensioner or Surviving Spouse under this Program, or

c. resides outside the United States or Puerto Rico, or

d. is a dependent of an employee who retires on or after January 1, 2005 and who was a part-time participant as defined in the pension agreement under which they retired.

Enrollment and Effective Date of Coverage

4.8 You will be enrolled in this Program at the time you first become eligible.

4.9 Coverage of a pensioner or surviving spouse becomes effective on the latest of:

a. January 1, 2023;

b. if you are a pensioner, the first day of the month in which you commence to receive a pension under the Company pension plan; or

c. if you are a pensioner that has applied for a "permanent disability pension benefit" (either a Disability Benefit from the Steelworkers Pension Trust or a permanent incapacity pension under the Company pension plan), you may elect to continue your coverage under the Program of Insurance Benefits (PIB) as active COBRA coverage to avoid loss of coverage during the application process with a monthly premium equal to the applicable monthly premium for PHMB coverage, provided that the COBRA coverage period is extended for no more than an additional six months. The PHMB coverage will be effective the first day of the month following the later of (i) the month the active COBRA coverage ends or (ii) the month that such permanent disability pension benefit becomes effective; or

d. if you are a surviving spouse, the first day of the month following the month in which

(1) your spouse died provided you make application for a Surviving Spouse's benefit within 90 days of the date of death of your spouse or

(2) you make application for a Surviving Spouse's benefit, if later.

4.10 Coverage of a dependent becomes effective on the later of

a. the date your coverage becomes effective, or

b. the date you acquire such dependent, subject to the provisions of paragraph 4.12 and 4.13.

4.11 If you have eligible dependents, you will be enrolled for dependent coverage. However, should you and your spouse both be eligible for hospital-medical coverage under this Program or any other plan toward the cost of which the Company contributes, each will be enrolled for single coverage under the respective plan unless both choose to be covered under this Program or the other plan. In any event, any dependent children will be enrolled under the husband's coverage unless you and your spouse elect otherwise. Such an election may not be revoked within the first 12 calendar months following the month in which the election is made. In the event coverage of either you or your spouse is terminated, that individual and that individual's eligible dependents will be enrolled as dependents of the covered person.

Change in Family Status

4.12 Prompt written notice of any change in your family status, such as marriage or divorce, birth of a child, marriage of any of your dependent children, or death of any dependent, should be sent to the Company.

When sending such notice be sure to include your full name and Social Security number.

4.13 If you are a pensioner enrolled for personal coverage only and thereafter marry or otherwise acquire a dependent, dependent coverage will become effective on the date you acquire such dependent if you notify the Company promptly. If you do not notify the Company within 30 days after the date you acquire such dependent you may be required to submit proof of such date.

Non-Duplication

4.14 The hospital, physicians' services and optional major medical benefits of this Program will not be payable to the extent they are provided under any other group plan if the other plan:

a. does not include a coordination of benefits or non-duplication provision, or

b. includes a coordination of benefits or non-duplication provision and is the primary plan as compared to this Program.

4.15 In determining whether this Program or another group plan is primary, the following will apply:

a. The plan covering the patient as a person in active employment or as a dependent of such person is the primary plan except that, if the person in active employment is the spouse of a pensioner and the patient is the pensioner or the dependent child of a pensioner, this Program will be primary when the other plan provides that this Program is primary.

b. Notwithstanding (a) above, if the parents of a dependent child are separated or divorced, benefit determination will be as follows:

(1) if there is a court decree which establishes financial responsibility for the medical expenses of such child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other plan which covers the child as a dependent;

(2) if there is no court decree and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody;

(3) if there is no court decree and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers that child as a dependent of the stepparent, but the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

c. Where the determination cannot be made in accordance with (a) or (b) above, the plan which has covered the patient for the longer period of time is the primary plan.

Note: In any case where this Program is determined to be secondary, benefits otherwise payable under this Program are reduced by benefits paid by the other plan, except major medical benefits are calculated by reducing Covered Medical Expenses under this Program by the other plan payment.

4.16 As used herein, "group plan" means

a. any plan covering individuals as members of a group and providing hospital or medical care benefits or services through group insurance or a group prepayment arrangement, or

b. any plan covering individuals as employees of an employer and providing such benefits or services, whether on an insured, prepayment or uninsured basis.

4.17 For the purpose of this provision, the Claims Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which may be necessary regarding coverage, expenses and benefits.

4.18 Any person claiming benefits under this Program must furnish the Claims Administrator such information as may be necessary for the purpose of administering this provision.

Subrogation

4.19 In the event any hospital, physicians' services and/or major medical benefits are provided under this Program to you or to one of your dependents, the Claims Administrator shall be subrogated and succeed to your rights of recovery therefore against any person, firm, corporation or organization except against insurers on policies of insurance issued to you as an individual. You will be required to execute and deliver documents and take such other action as the Claims Administrator may require to secure such rights. You and your dependent will be notified in the event the Claims Administrator elects to enforce its right of subrogation.

No-Fault

4.20 The benefits otherwise payable under this Program will be offset by similar benefits payable for medical expenses or which would be payable upon timely and proper submission of claim (unless good and sufficient reason is shown for your inability to submit such claim or to have such claim submitted by someone else on your behalf), under any insurance policy, bond, fund, or other arrangement required by any motor vehicle insurance law requiring the provision of benefits for personal injury without regard to fault. The benefits of this Program will not be offset if the provisions of such law require that other insurance benefits be utilized before benefits are available pursuant to such law or you have obtained no-fault insurance at a lower cost because of your coverage under this Program.

Overpayments

4.21 In the event that an overpayment of hospital, physicians' services or major medical benefits occurs as a result of the application of the non-duplication, subrogation or no-fault provisions, the Claims Administrator will have the right to recover any payment already made which is in excess of its liability. You will be required to give any necessary authorization to permit deduction of any such overpayment from any amounts payable to you under the Company pension plan. Whenever benefits which are payable under this Program have been provided under another group plan, the Claims Administrator may make reimbursement direct to the insurance company or other organization providing benefits under the other group plan.

Termination of Coverage Under the Program

4.22 Coverage for eligible Pensioners and Surviving Spouses under the Program terminates on the earliest of:

a. the day on which such person ceases to be eligible for coverage under this Program;

b. the end of the month in which notice from such person is received by the Company (see paragraph 4.11) requesting termination of coverage under this Program;

c. the end of the month for which you last paid the required monthly premium pursuant to paragraph 4.2;

4.23 Coverage under the Program of a dependent of a pensioner or a surviving spouse terminates on the earliest of:

a. the day immediately preceding the date such person ceases to be an eligible dependent, except as provided in (b) below;

b. the end of the month in which a dependent child attains age 19 unless such dependent qualifies as a full-time student or is totally disabled (see paragraphs 4.39 through 4.43); or

c. the date coverage terminates for the pensioner or surviving spouse except that coverage of a dependent continues until the end of the month in which a pensioner or surviving spouse dies (see paragraph 4.0 and 4.8 if the pensioner dies and the pensioner's dependent spouse is eligible for a Surviving Spouse's benefit under the Company pension plan).

4.24 Major Medical coverage under the Program of any pensioner, surviving spouse or dependent terminates as of the end of the month in which the maximum lifetime benefit is reached.

Once you voluntarily terminate coverage, you will not have the opportunity to again enroll, except that if you voluntarily deferred such coverage because you are eligible for major medical coverage under any other employer's insurance program when you first become eligible, you may again elect coverage provided you notify the Company (see paragraph 4.1) within 30 days of the termination of the other coverage.

Continuation of Coverage Pursuant to Consolidated Omnibus Budget Reconciliation Act (COBRA)

4.25 If coverage under this Program terminates for one of the reasons set forth in (a), (b), or (c) below, the person(s) whose coverage terminates may elect to continue the coverages described in Sections 1, 2, 3, and 4 of this booklet, whichever are applicable, without evidence of insurability for up to 36 months, subject to payment of the full cost of the coverage elected.

a. If you are the spouse of a pensioner and coverage terminates because of divorce or legal separation from the pensioner, or because the pensioner dies and you are not eligible for a Surviving Spouse's benefit under the Company pension plan;

b. If you are the dependent child of a pensioner or surviving spouse and coverage terminates for any of the following reasons:

(1) Death of parent(s);

(2) Parents' divorce or legal separation; or

(3) Your ceasing to be an eligible dependent as defined in paragraph 4.4 of this booklet;

c. If you are the surviving spouse of a pensioner or former employee of the Company and coverage terminates because of remarriage.

4.26 In order to elect continuation under this Program, you, your spouse and/or dependent children must notify the Plan Administrator (see paragraph 4.12 is family status change 4.25 is COBRA?) within 60 days of the date of your divorce or legal separation, the death of the pensioner, pensioner's spouse or surviving spouse, or a child's loss of dependent status. Upon such notification, the Company will notify you, your spouse and/or dependent children as to eligibility for continuation of coverage under this Program and the applicable cost of each. If you, your spouse and/or your children wish to continue coverage, an election to do so must be received within 60 days from the later of:

a. the date coverage terminated or

b. the date of notification by the Company of eligibility for continuation of coverage. The first premium payment must be received by the later of the due date shown on the initial bill or within 45 days after the election form is signed. Premiums are payable monthly in advance and subsequent premiums are due 30 days after the due date shown on each monthly bill.

4.27 The 36-month period referred to in paragraph 4.25 may be shortened for any of the following reasons:

a. The Company no longer provides retiree health care coverage to any group of retirees;

b. Failure to pay the premium within the prescribed time limits for continuing coverage;

c. The person who is continuing coverage becomes

(1) covered under another group health or medical plan or

(2) covered under Medicare; or

d. The person who is continuing coverage requests cancellation in writing.

4.28 When coverage under the COBRA provisions of this Program terminates, the conversion provisions in paragraphs 4.35 and 4.36 of this booklet, or the applicable conversion provisions apply.

Medicare

4.29 If you or a dependent of yours is or upon proper application would be entitled without charge to hospital insurance benefits under Part A (Hospital Insurance Benefits) of Title XVIII of the Social Security Act-Health Insurance for the Aged and Disabled (Medicare), you or such dependent shall be considered to be so entitled on the first day on which you or such dependent is or upon proper application would become so entitled, whether or not proper application has been made; if you or a dependent of yours is entitled, or upon proper application would be entitled, by reason of attainment of age 65 or disability to payments under Part B of Medicare (Supplementary Medical Insurance Benefits), you or such dependent shall be considered to be so entitled on the first day on which you or such dependent is or upon proper application would become so entitled, whether or not enrollment in the insurance program established by such Part B has been accomplished.

4.30 Payment under this Program shall be the benefit which would otherwise be payable under this Program reduced by the amount of benefits which you or your dependent receives, or would upon application receive under Medicare A or Medicare B (including any additional hospital benefits payable from the lifetime reserve of additional hospital days provided under Medicare A).

Note: In calculating optional major medical benefits under the Program, the reduction is applied to Covered Medical Expenses.

4.31 It is most important that when you or a dependent of yours approaches age 65, you or such dependent enroll for Medicare A (if Medicare A is available without charge) and accept enrollment for Medicare B at the nearest Social Security Office during the three-month period before the 65th birthday. It is also most important that if you or a dependent of yours becomes eligible for Medicare B by reason of disability, you or such dependent accept enrollment for Medicare B following notification by the government of your automatic enrollment in Medicare A and your eligibility for Medicare B. Such timely enrollment will avoid the loss of valuable protection against medical expenses.

4.32 You must also advise the Company immediately of the effective date of such Medicare coverage applicable to you or to one of your eligible dependents. Failure to do so could result in overpayment of benefits, which amount would have to be repaid by you.

4.33 If you are not eligible for Medicare and if your spouse attains age 65 and is entitled to benefits under Medicare A but only upon payment of a premium (because, for example, your spouse is not then eligible for Social Security benefits), it is recommended that your spouse:

a. not enroll for Medicare A since the Company will not reimburse you for the Medicare A premium. Should your spouse enroll for Medicare A by paying such premium, any payment under this Program shall be the benefit which would otherwise be payable under this Program reduced by the amount of reimbursement provided under Medicare A for such confinements, services, supplies or treatments covered under this Program.

b. enroll for Medicare B and pay the Medicare B premium since payment under this Program shall be the benefit which would otherwise be payable under this Program reduced by the amount of reimbursement provided under Medicare B for such services, supplies or treatments covered under this Program whether or not your spouse enrolls for Medicare B. For any month in which your spouse is covered under this Program and is enrolled for Medicare B, the Company will reimburse you for the Medicare B premium, provided you advise the Company of your spouse's enrollment in Medicare B and eligibility for Medicare A only upon payment of a premium.

Note: In calculating optional major medical benefits under the Program, the reduction referred to in (a) and (b) above is applied to Covered Medical Expenses.

Benefits While Traveling Outside the United States or Puerto Rico

4.34 If you or a dependent of yours is hospitalized and/or treated by a physician while traveling outside the United States or Puerto Rico, you will probably be required to pay the provider for such services since hospitals and physicians in foreign countries generally do not honor the Claims Administrator or Medicare Identification Cards. Be sure to obtain itemized receipts detailing the dates and types of services performed and the charges incurred. Such receipts are then to be submitted to the Claims Administrator for reimbursement on the same basis as if the expenses were incurred in the United States. If the person incurring the expenses is covered under this Program and is eligible for Medicare but Medicare benefits are not payable because Medicare does not cover care outside the United States (except for certain services incurred in Canada or Mexico), benefits will be provided under this Program as if such person were not eligible for Medicare.

Hospital and Surgical Conversion Privilege

4.35 Upon application to the Claims Administrator within 31 days after your coverage under the Program terminates, you may obtain an individual policy providing at your option either hospital insurance only or hospital and surgical insurance. The converted policy may be obtained by making application to the Claims Administrator and will provide the benefits, call for the premiums and include the provisions applicable to such forms of policy then being issued by the Claims Administrator. In the event of your death, your dependents have the same privilege of continuing protection.

4.36 Maternity and obstetrical benefits will be provided after termination of your group coverage only if you apply for a converted policy of hospital and surgical insurance. If you convert, you and your dependents will be eligible for the maternity and obstetrical benefits provided by the converted policy while such policy is in effect.

Continuous Service

4.37 Wherever the term "continuous service" is used in this booklet, it means your continuous service as determined for pension purposes under the Company pension plan applicable to you.

State or Federal Laws

4.38 If any state or federal legislation shall be enacted to provide benefits similar to those described in this booklet, appropriate adjustments will be made in the provisions of this Program.

Full-Time Students

4.39 In order for a dependent child to be eligible for coverage under the Program as a full-time student after attainment of age 19, the child:

a. Must be under 25 years of age and otherwise meet the Program definition of a dependent child under 19 years of age;

b. Must not be employed on a regular full-time basis;

c. Must not be paid by another employer while in school at the request of that employer;

d. Must not be covered under any other employer group insurance or prepayment plan;

e. Must be enrolled full time in a recognized course of study or training and in active full-time attendance at an institution such as a

(1) High school or vocational school supported or operated by state or local governments, or by the Federal Government.

(2) State university or college or community college.

(3) Licensed private school, college or university.

(4) Licensed technical school, nurses' training school, beautician school, automotive school, or similar training school.

4.40 At least annually, the Claims Administrator will request information regarding dependent student verification. It is your responsibility to complete the questionnaire and return it to the Company as instructed on the questionnaire within 30 days. If you fail to return the questionnaire to the Company within 30 days, your dependent's coverage may be cancelled. In the event of such termination, coverage will be restored retroactively if the required information is provided and it verifies the dependent's eligibility.

4.41 The eligibility of a dependent who qualifies as a full-time student for coverage under the Program will continue during:

a. A regularly scheduled vacation period or between-term period as established by the institution. Work limited to such period is not considered employment on a regular full-time basis.

b. A period of absence from class due to disability for up to four months following the end of the month in which such disability occurred provided that the student continues to be enrolled in the institution.

4.42 The student's eligibility will terminate at the end of the month in which their full-time student status ends either by

a. graduation or completion of the course,

b. other termination of full-time attendance at the institution, or

c. upon attainment of age 25.

It will then be your responsibility to arrange for the Claims Administrator contract, direct payment basis, as provided under paragraph 4.25, within 60 days of such date.

Disabled Children

4.43 In order for a dependent child to be eligible for coverage under this Program as a disabled child after attainment of age 19, the child:

a. Must otherwise meet this Program's definition of a dependent child under 19 years of age or a full time student if age 19 or older;

b. Must be incapable of self-support because of a continuously disabling illness or injury which commenced prior to age 19 or while a full time student if age 19 or older; and

c. Must be principally supported by the pensioner or the individual receiving a Surviving Spouse's benefit.

4.44 If you believe that a dependent of yours meets the disability criteria above, you should secure from the Human Resources office at your former place of employment the Disabled Dependent Certification form which must be completed by you and the attending physician and returned to that office within 90 days of the date such dependent attains age 19. That form will be reviewed by the Claims Administrator to determine the eligibility of such a dependent for benefits under the Program and you may be required to submit additional information in connection with such eligibility determination. You will be notified as to whether or not the dependent is eligible for benefits of the Program as a disabled child. If such eligibility is approved, you will be further required, usually not more frequently than once a year, to furnish the Claims Administrator satisfactory evidence to substantiate the continued eligibility of such a dependent for benefits under the Program.

Optional Dental and Vision Insurance

4.45 The Company will make available a voluntary dental plan through MetLife and vision plan through EyeMed.

Pensioners' and Surviving Spouses' Health Insurance Agreement

Between

EMPIRE IRON MINING PARTNERSHIP

AND TILDEN MINING COMPANY L.C.

THE CLEVELAND-CLIFFS IRON COMPANY, Managing Agent

and the

UNITED STEEL, PAPER AND FORESTRY, RUBBER, MANUFACTURING, ENERGY, ALLIED INDUSTRIAL AND SERVICE WORKERS INTERNATIONAL UNION

Effective January 1, 2023

HEALTH INSURANCE AGREEMENT

AGREEMENT dated January 1**,** 2023, between Empire Iron Mining Partnership and Tilden Mining Company, L.C. and The Cleveland-Cliffs Iron Company, Managing Agent (the "Company") and the United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union (the "Union").

Definitions

1. Wherever used herein:

   (a) "Pensioner" means an individual who retired under the Company pension plan on other than a deferred vested pension, on or after September 1, 2004 and at the time of retirement had 15 or more years of continuous service from the bargaining unit.

   (b) "Surviving Spouse" means an individual who is receiving a Surviving Spouse's benefit under the Pension Agreement effective January 1, 2023 between the Company and the Union by reason of the death of a person (hereinafter "Decedent") who at the time of death was retired on or after September 1, 2004 from the bargaining unit.

   (c) "Pensioners and Surviving Spouses' Health Insurance" means the Program of Hospital-Medical Benefits (hereinafter "Program") established by this Agreement and described in the booklet adopted by the parties which constitutes a part of this Agreement as though incorporated herein.

   (d) "Prior Program" means the Program of Hospital and Physicians' Services Benefits which was established by an agreement dated January 1, 2019 between the Company and the Union.

Pensioners' and Surviving Spouses' Health Insurance

2. The Program shall be applicable to Pensioners and Surviving Spouses in accordance with the provisions of this Agreement, subject to the following provisions:

   (a) Except as provided in (b) and (c) below, in no event shall any benefit provisions of the Program be applicable (i) to any period prior to January 1, 2023 nor (ii) to any part of a period of continuous hospitalization or Skilled Nursing Facility Care which commenced prior to the later of January 1, 2023 or the effective date of coverage under the Program.

   (b) The benefits of the Prior Program unless otherwise specified herein shall be applicable to any occurrence prior to January 1, 2023, subject to all of the provisions of the Prior Program, except that to the extent hospital and physicians' services benefits related to such occurrence are payable for a period extending beyond December 31, 2022, the benefits otherwise payable shall be conformed to

the benefits provided under the Program, and will be payable for the period provided under the Program reduced by the amount of or the period for which benefits were paid prior to January 1, 2023.

(c) Optional Major Medical Benefits will be payable for any part of a continuous period of hospitalization that extends beyond the effective date of coverage under the Program if the person confined was covered under the Prior Program as of December 31, 2022 and the Pensioner or Surviving Spouse enrolls for Optional Major Medical Benefits.

Cost of Benefits

3. The cost of the Program shall be paid by the Company except as provided in paragraph 4.2, 4.3, 4.25, and 4.45 of the Program.

Requirements of Law

4. It is intended that the provisions for the insurance benefits which shall included in the Program shall comply with and be in substitution for the provisions for similar benefits which are or shall be made by any applicable law or laws. Where, by agreement, certain benefits under the Program are provided under law rather than under the Program, the Company will pay any direct contribution required of any pensioner or surviving spouse by law on account of such benefits, except as otherwise provided in the Program with respect to the Medicare Part B premium. The Company shall, after consultation with the Union, reduce the benefits of the Program to the extent that benefits provided under any law would otherwise duplicate any of the Program benefits.

Administration of the Program

5. The Program shall be administered by the Company or through arrangements provided by it. Any contracts entered into by the Company with respect to the benefits of the Program shall be consistent with this Agreement and shall provide benefits and conditions conforming to those set forth in the booklet.

Continuation of Coverage

6. Any pensioner or individual receiving a Surviving Spouse's benefit who shall become covered by the Program established by this Agreement shall not have such coverage terminated or reduced (except as provided in the Program) so long as the individual remains retired from the Company or receives a Surviving Spouse's benefit, notwithstanding the expiration of this Agreement, except as the Company and the Union may agree otherwise.

Term of This Agreement

7. This Agreement shall become effective as of January 1, 2023, and shall remain in effect until February 1, 2027 and thereafter subject to the right of either party on 120 days' written notice served on or after September 1, 2026 to terminate this Agreement.

UNITED STEELWORKERS	**EMPIRE IRON MINING PARTNERSHIP AND TILDEN MINING COMPANY, L.C. AND THE CLEVELAND-CLIFFS IRON COMPANY, MANAGING AGENT**
/s/ Tom Conway	/s/Rob Fischer
/s/ Emil Ramirez	
/s/ Donnie Blatt	

APPENDIX A

October 1, 2022

Mr. Emil Ramirez
Director, District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Group Medical Cost Neutrality in the Event of National Health Care

Dear Mr. Ramirez:

In the event that National Health Care program is enacted, and such program provides insurance benefits which had been provided by the Programs of Insurance Benefits for both active employees and Eligible Pensioners and Surviving Spouses (PIBs) and/or the Programs of Hospital Medical Benefits for Eligible Pensioners and Surviving Spouses (PHMBs) in effect at the time enactment, the parties will meet to discuss the impact the legislation and any modifications to the insurance programs which may be necessary or desirable.

Where, by agreement, certain benefits under the insurance programs are provided under law rather than under the PIBs or PHMBs, the Company will pay the amount required to be paid to insure that participant's coverage is no less than their coverage under the PIBs and PHMBs in which they were enrolled that are in effect at the time of enactment. Except as specifically excluded under the PIBs or PHMBs (for example, Medicare Part B premiums, for a Medicare-eligible retiree), this shall not result in persons covered by the PIBs or PHMBs having to pay additional deductibles, copayments, or contributions in excess of the amounts provided for in the PIBs or PHMBs. Any resulting personal tax liability is the responsibility of the employee, retiree or surviving spouse; however, the Company and Union will meet thereafter to explore methods of reducing this liability.

If the Company is required under the law to provide benefits to participants in excess of the benefits provided under the PIBs and PHMBs in which they are enrolled or as required by law at the time of enactment, the amounts required to be paid for these benefits shall be paid entirely by employees or retirees/surviving spouses.

As soon as practicable following enactment, an actuary selected by the Company will perform a calculation using reasonable actuarial assumptions and methods to determine the amount of savings realized. These savings will be reduced by any premiums, taxes or contributions specifically designated for the purpose of financing the national program which are required of the Company by law. The resulting net savings, if any, will be used to offset the increased employee and retiree/surviving spouse costs referenced in the preceding paragraphs via methods mutually agreed to by the Company and the Union. Any net savings in excess of the offset amount will be shared equally between the Company and the employees and retirees/surviving spouses.

If any differences shall arise between the Company and the Union regarding the implementation of the matters described above, such matters shall be referred to the Chairperson

of the Union's Negotiating Committee and the Chairperson of the Company's Negotiating Committee for resolution. If the Chairpersons are unable to resolve the disputes, the disputes shall be referred to a mutually agreeable third party for binding arbitration.

Furthermore, the parties agreed that during the negotiations for a successor Labor Agreement to the 2022 Labor Agreement they shall attempt to reach agreement regarding the application of any cost savings to the Company resulting from benefits being provided under law which would otherwise duplicate any of the benefits provided under the PIBs and PHMBs in effect at the time of enactment.

Very truly yours,

Rob Fischer
Vice President, Human Resources & Labor Relations
The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership and Tilden Mining Company L.C.

Confirmed:
Emil Ramirez
Director, District 11

APPENDIX B

LETTER OF UNDERSTANDING REGARDING ACCESS TO CENTERS OF EXCELLENCE UNDER THE PPO PROGRAM

October 1, 2022

Mr. Emil Ramirez, Director
District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Centers of Excellence

Dear Mr. Ramirez:

This is to confirm our understanding that participants in the Program of Insurance Benefits (PIB) and Program of Hospital-Medical Benefits for Eligible Pensioners and Surviving Spouses (PHMB) will continue to have access to centers of excellence in accordance with the negotiated Managed Health Care protocols.

In addition, participants in the PIB and PHMB will have access to enhanced transplant services through the Blue Cross and Blue Shield Blue Quality Centers for Transplant.

Managed care participants may elect to utilize "Centers of Excellence" for medical services or procedures that are difficult, costly or specialized and where such treatment would be likely to reduce costs or improve the outcome. Centers of Excellence are health care institutions that have gained professional recognition through specialized clinical expertise and equipment acquisitions, and are able to provide major resource-intensive procedures in a more effective and efficient manner than may be possible elsewhere in the region.

Coverage for medical services received at a Center of Excellence may vary depending on whether or not prior authorization has been obtained and whether the Center of Excellence is a participating provider in the BCBS PPO network.

Coverage for medical services at a Center of Excellence which is a participating provider in the BCBS PPO network will be provided at the in-network benefit level. If prior authorization is obtained or a denial is successfully appealed, transportation for the participant and a family member to the Center of Excellence will also be paid for, including lodging for the family member.

If authorization is not obtained for medical services at a Center of Excellence which is a participating provider in the BCBS PPO network or the appeal regarding the status of the

provider as a Center of Excellence is denied, coverage will still be provided at the in-network benefit level, but transportation expenses will not be covered

Coverage for medical services at a Center of Excellence which is not a participating provider in the BCBS PPO network requires pre-authorization. If authorization is obtained, coverage will provided at the in-network benefit level and transportation expenses will be covered. **To qualify for this benefit, the member must reside more than 150 miles from the Center of Excellence.** If authorization is not obtained or an appeal regarding the status of the provider is denied, coverage will provided at the lower out-of-network benefit level and travel expenses will not be covered.

Authorization of medical services at a Center of Excellence and the determination that a provider is a Center of Excellence, as described above, will be made on a case by case basis after consultation with the participant or family, physician(s) and Anthem BCBS. In the event of a dispute over whether a facility is a "Center of Excellence," the matter will be referred to representatives of the Company and Union for resolution.

Examples of such Centers of Excellence are attached, however these are only examples. Participants should consult with their physician and Anthem BCBS for other hospitals and specialties.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations
The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership and Tilden Mining Company L.C.

Confirmed:
Emil Ramirez
United Steelworkers

Exhibit A

Centers of Excellence

Note: The following is a partial list of Centers of Excellence and is only for illustrative purposes. Participants should consult with their physician and Anthem BCBS for other hospitals and specialties.

Cancer
Mayo Clinic
University of Chicago Hospital
Johns Hopkins Hospital, Baltimore
Cleveland Clinic
William Beaumont Hospital, Royal Oak, Michigan

Digestive Disorders
Mayo Clinic
Johns Hopkins Hospital, Baltimore
Cleveland Clinic
University of Chicago Hospital
William Beaumont Hospital, Royal Oak, Michigan

Ear, Nose & Throat
Mayo Clinic
Johns Hopkins Hospital, Baltimore
University of Iowa Hospitals and Clinics, Iowa City
Henry Ford Hospital, Detroit
Cleveland Clinic

Eyes
Mayo Clinic
Johns Hopkins Hospital (Wilmer Eye Institute), Baltimore
University of Iowa Hospitals and Clinics, Iowa City
Cleveland Clinic
University of Illinois Hospitals and Clinics, Chicago

Gynecology
Mayo Clinic
Johns Hopkins Hospital, Baltimore
Cleveland Clinic
Northwestern Memorial Hospital, Chicago
William Beaumont Hospital, Royal Oak, Michigan

Heart and Heart Surgery
Mayo Clinic
Cleveland Clinic
Johns Hopkins Hospital, Baltimore
Henry Ford Hospital, Detroit
William Beaumont Hospital, Royal Oak, Michigan

Kidney Disease
Mayo Clinic
Cleveland Clinic
Johns Hopkins Hospital, Baltimore
University of Chicago Hospitals
Henry Ford Hospital, Detroit

Neurology and Neurosurgery
Mayo Clinic
Johns Hopkins Hospital, Baltimore
Cleveland Clinic
Henry Ford Hospital, Detroit
University of Chicago Hospital

Orthopedics
Mayo Clinic
Cleveland Clinic
Johns Hopkins Hospital, Baltimore
University of Iowa Hospitals and Clinics, Iowa City
University of Chicago Hospital
Henry Ford Hospital, Detroit

Pediatrics
Mayo Clinic
Johns Hopkins Hospital, Baltimore
Children's Hospital of Pittsburgh
University Hospitals of Cleveland (Rainbow Babies & Children's Hospital)
Children's Memorial Hospital, Chicago

Respiratory Disorders
Mayo Clinic
Cleveland Clinic
Johns Hopkins Hospital, Baltimore
University of Chicago Hospitals
Henry Ford Hospital, Detroit Henry Ford Hospital, Detroit

Rheumatology
Mayo Clinic
Cleveland Clinic
Johns Hopkins Hospital, Baltimore
University of Chicago Hospitals
University of Iowa Hospitals and Clinics, Iowa City

Urology
Mayo Clinic
Cleveland Clinic
Johns Hopkins Hospital, Baltimore
Henry Ford Hospital, Detroit Henry Ford Hospital, Detroit
University of Chicago Hospitals

APPENDIX C
Letter of Understanding

October 1, 2022

Mr. Emil Ramirez, Director
District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Letter of Understanding on Joint Committee to Monitor Health Benefits Claims Administration and Establish Periodic Sessions for Bargaining Unit Employees and Retirees

Dear Mr. Ramirez:

A senior claims representative of Anthem Blue Cross/Blue Shield (and Express Scripts at least annually) shall be available in the areas of Ishpeming-Negaunee, Michigan for at least two full days each calendar quarter for the purpose of meeting with employees, retirees or dependents to review on an individual basis medical and prescription drug care claim adjudication issues or problems. Upon the request of the Local Unions at Hibbing and United Taconite, meetings with claims representative of Anthem Blue Cross/Blue Shield and Express Scripts may be held in the Hibbing and Eveleth, Minnesota

The meetings shall be held at a centrally convenient location within the area. Notices regarding the dates, times and place of such meetings shall be mailed by the Company to all employees and retirees no later than two weeks prior to such meetings. One of the two days of meetings will be held at the union hall if so requested by the local unions.

Additionally, three local union representatives (one from each Local Union and the applicable USW Contract Coordinator) and three Company representatives (one of whom shall include a Corporate Benefits Department representative) shall form a sub-committee which shall meet annually (or more frequently if necessary) to provide guidance and direction on general claim administration issues. There shall be one sub-committee for Hibbing and United Taconite and a separate sub-committee for Empire and Tilden. The Company will arrange and provide HIPAA training for the applicable Union-designated Contract Coordinators.

Responsibilities of the sub-committee shall be:

- To examine all general claim administrative problem areas and recommend appropriate corrective action.
- The sub-committee shall jointly travel to the Claims Administrator's office up to twice a year, if necessary, to resolve claims administration issues within the responsibility of this sub-committee.

- To examine suspended claim logs and make recommendations to expedite such matters.
- To oversee the effectiveness of meetings with employees, retirees and dependents and recommend appropriate changes to improve their effectiveness.

For purposes of this sub-committee, claim administrative issues shall be deemed to include life insurance and sickness and accident benefits in addition to health care benefits (which includes medical, dental, vision care and prescription drugs).

The formation of the sub-committee shall not replace or eliminate the claim appeal provisions of the Program of Insurance Benefits for active employees or the Program of Hospital-Medical Benefits for retirees. The sub-committee shall not have the authority to modify any plan benefit limitation, exclusion or provision.

In the event that the sub-committee cannot reach mutual agreement on subjects within their scope of responsibility, such open subjects shall be referred to the Managed Care Oversight Committee, and then the USW District 11 Director or respective designee and the Senior Vice President of Human Resources or respective designee for review and resolution.

The Company shall agree to pay lost wages and travel expenses for union members of the sub-committee which participate in the joint meetings set forth herein.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations
The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership and Tilden Mining Company L.C.

Confirmed:
Emil Ramirez
United Steelworkers

APPENDIX D

October 1, 2022

Emil Ramirez
Director, District 11
Chairman, Negotiating Committee
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Retiree Medical Cap Issues

Dear Mr. Ramirez:

This letter confirms the parties' understanding with respect to certain issues related to the FAS ASC 715-60 (f/k/a/ FAS 106) Cap in the Program of Hospital-Medical Benefits for Eligible Pensioners and Surviving Spouses who retired on or after September 1, 2004.

The term "per capita" shall mean covered lives which include Pensioners and Pensioners' dependent spouses.

Pensioners who retire on or after January 1, 2015 will have their monthly medical premium adjusted effective May 1, 2015 to reflect the application of the Per Capita Maximum Cap.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations
On behalf of The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership and
Tilden Mining Company L.C. and
Cliffs Mining Company, as Managing Agent for
United Taconite LLC and Hibbing Joint Venture

Confirmed:
Emil Ramirez
Director, District 11
Chairman, Negotiating Committee
United Steelworkers

APPENDIX E

October 1, 2022

Emil Ramirez
Director, District 11
Chairman, Negotiating Committee
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Retiree Medical

Dear Mr. Ramirez:

The parties agree that retiree medical insurance may be negotiated by the parties as part of bargaining for the successor agreements to those negotiated in 2022.

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations
On behalf of The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership and
Tilden Mining Company L.C. and
Cliffs Mining Company, as Managing Agent for
United Taconite LLC and Hibbing Joint Venture

Confirmed:
Emil Ramirez
Director, District 11
Chairman, Negotiating Committee
United Steelworkers

APPENDIX F

October 1, 2022

Emil Ramirez
Director, District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Eligibility

Dear Mr. Ramirez:

Employees hired prior to September 1, 2016 and who meet the eligibility requirements for retiree health & life benefits will continue to be eligible for Non-Medicare (i.e. Pre-65) retiree health & life coverage and Medicare-Eligible (i.e., Post-65) retiree health & life coverage.

An employee whose original date of hire occurred before September 1, 2016 and who breaks pension continuous service due to a layoff from the Company after September 1, 2016 and is rehired, shall regain eligibility to become a participant under the Company's various Program of Hospital and Medical Benefits Agreements if such rehire is within 5 years of the last day worked during a prior period of employment.

Employees hired or rehired on or after September 1, 2016, except as noted above, will not be eligible for benefits under the Company's various Program of Hospital and Medical Benefits Agreements. Contributions to the Retiree Health Care Account, as defined in the BLA, are in lieu of retiree health and life benefits.

The Retiree Health Care Account portion of the employee's 401(k) balance will not be eligible for loans, hardship withdrawals or early distributions. Contributions will be initially invested in an appropriate age-based, target-date fund.

All such contributions to the Retiree Health Care Account will be immediately vested.

Very truly yours,

Rob Fischer
Vice President, Human Resources & Labor Relations
On behalf of The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership and
Tilden Mining Company L.C. and
Cliffs Mining Company, as Managing Agent for
United Taconite LLC and Hibbing Joint Venture

Confirmed:
Emil Ramirez
United Steelworkers

APPENDIX G

Letter of Understanding

October 1, 2022

Mr. Emil Ramirez, Director
District 11
United Steelworkers
3433 Broadway St. NE, Suite 315
Minneapolis, MN 55413

Re: Medicare Advantage Prescription Drug Plan

Dear Mr. Ramirez:

The Companies will provide all Medicare-eligible retirees, Medicare-eligible spouses, and Medicare-eligible surviving spouses coverage under an Anthem Medicare Advantage plan with the same plan design as provided to the retirees of Cleveland-Cliffs Steel at the rates outlined in Section 4.2. These changes will be effective January 1, 2023.

Furthermore, the Companies agree to provide Preventive Dental coverage through the Medicare Advantage Plan, which is included in the cost. .

Very truly yours,
Rob Fischer
Vice President, Human Resources & Labor Relations
On behalf of The Cleveland-Cliffs Iron Company,
as Operating Agent for Empire Iron Mining Partnership and
Tilden Mining Company L.C. and
Cliffs Mining Company, as Managing Agent for
United Taconite LLC and Hibbing Joint Venture

Confirmed:
Emil Ramirez
United Steelworkers