LODA HEALTH BENEFITS PLANS
LODA Plan - Medicare Primary

Summary Plan Description

July 2017

Administered by the Department of Human Resource Management
Commonwealth of Virginia

A10347 (7/2018)

TABLE OF CONTENTS

GENERAL PLAN INFORMATION

TYPE OF PLAN AND ADMINISTRATION

The Plan is a health and welfare benefit plan that offers self-funded benefits and a Medicare Part D subsidy to eligible individuals.

FORMAL PLAN NAME: LODA Plan – Medicare Primary

PLAN NUMBER: 503

PLAN YEAR: January 1 through December 31

PLAN SPONSOR

Commonwealth of Virginia
101 N. 14th Street, 12th Floor
Richmond, VA 23219

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 54-6024817

PLAN ADMINISTRATOR

Department of Human Resource Management
Commonwealth of Virginia
101 N. 14th Street, 12th Floor
Richmond, VA 23219

If you have questions about benefit administration, you may contact the Plan Administrator. The Plan Administrator has the sole discretionary authority to construe the terms of the Plan and all facts surrounding claims under the Plan (such as whether an individual is eligible for coverage under the Plan), and shall determine all questions arising in the administration, interpretation, and application of the provisions of the Plan. All determinations of the Plan Administrator shall be conclusive and binding on all parties.

CLAIMS FIDUCIARY

While the Plan Administrator is the Named Fiduciary, third parties that administer claims are fiduciaries with respect to decisions regarding whether the claim for benefits will be paid under the Plan.

AGENT FOR SERVICE OF LEGAL PROCESS

Office of the Attorney General
Commonwealth of Virginia
202 North Ninth Street
Richmond, VA 23219

Service of Process may also be served on the Plan Administrator.

IMPORTANT NOTICE

This summary plan description tells you what medical services are eligible for reimbursement under the LODA (Line of Duty Act) Plan – Medicare Primary. This Summary Plan Description constitutes the description of the benefits, exclusions and limitations under this plan. Medicare Part D provisions of the Outpatient Prescription Drug Coverage section of this Summary Plan Description are also described in the Evidence of Coverage provided by the Medicare Part D Prescription Drug Plan (PDP) Administrator for this plan.

Throughout this summary plan description there are words which begin with capital letters. In most cases, these are defined terms. See the Definitions section for the meaning of these words. All references to you, your, and yourself apply to the Enrollee/Participant.

Your coverage is limited to the services specifically described in this Summary Plan Description as eligible for reimbursement. There are specific exclusions for which the program will never pay. Even more important, payment for covered services is almost always conditional. That is, payment may be denied for covered services you receive without observing all of the conditions and limits under which they are covered.

Your benefits are governed strictly by the written provisions of the Plan. Only those services specifically named or described in this Summary Plan Description are covered. You are responsible for knowing what is covered and the limits and conditions of coverage. Furthermore, the terms and conditions of your coverage can be changed if proper notice is given to you.

GET HELP IN YOUR LANGUAGE

Curious to know what all this says? We would be too. Here's the English version:
This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Spanish
Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Amharic
ይህ ማስታወቂያ ስለማመልከቻዎ ወይም ጥቅማ ጥቅሞችዎ ጠቃሚ መረጃ አለው። አስፈላጊ ቀኖችን ይፈልጉ። ጥቅማ ጥቅሞችዎን ለማቆየት ወይም ክፍያዎችን ለመቆጣጠር በሆነ ቀን አንድ እርምጃ መውሰድ ያስፈልግዎ ይሆናል። ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ። (TTY/TDD: 711)

Arabic
يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو المزايا المقدمة لك. احرص على تتبع المواعيد المهمة. قد تحتاج إلى اتخاذ إجراء قبل مواعيد محددة للاحتفاظ بالمزايا أو لإدارة التكلفة. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. يُرجى الاتصال برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD:711).

Bassa
Bɔ̃i-po-po nìà kɛ ɓéɖé bɔ̃ kpaɖɛ ɓá nì ɖɛ-mɔ́-ɖìfèɖè mɔɔ kpáná-ɖè ɓě m̀ ké dyéɛ dyí. M̀ mɛ mɔ́ wé kpaɖɛ ɓě dyi. Ɓé nì kpáná-ɖè ɓě ké m̀ xwa se mɔɔ ɓɛ́ m̀ ké píó xwa ɓɛ́ìn nyɛɛ, ɔ mu wɛ̃ìn ɓɛ́ m̀ kéɔ́ ɖɛ ɓě ti kɔ̃ nyùìn. M̀ ɓéɖé dyí-ɓèɖɛ̀in-ɖèɔ̀ ɓɛ́ m̀ ké bɔ̃ nìà kɛ kè gbo-kpá-kpá dyé ɖé m̀ ɓíɖí-wùɖùŭn bó pídyi. Ɖá Méɓà jè gbo-gmɔ̀ Kpòè nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃ɔ̃ kɔ̃ɛ, bó gbo-kpá-kpá dyé jè. (TTY/TDD: 711)

Bengali
আপনার আবেদন বা সুবিধার বিষয়ে এই বিজ্ঞপ্তিটিতে গুরুত্বপূর্ণ তথ্য রয়েছে। গুরুত্বপূর্ণ তারিখগুলির জন্য দেখুন। আপনার সুবিধাগুলি বজায় রাখার জন্য বা খরচ নিয়ন্ত্রণ করার জন্য নির্দিষ্ট তারিখে আপনাকে কাজ করতে হতে পারে। বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আপনার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন। (TTY/TDD: 711)

Chinese
本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi
این اطلاعیه حاوی اطلاعات مهم در مورد درخواست یا مزایای شما است. به تاریخهای مهم دقت کنید. ممکن است لازم باشد در برخی تاریخهای خاص اقدامی انجام دهید تا مزایای خود را حفظ کنید یا هزینه‌ها را مدیریت کنید. شما این حق را دارید که این

اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید(TTY/TDD:711).

French
Cette notice contient des informations importantes sur votre demande ou votre couverture. Vous y trouverez également des dates à ne pas manquer. Il se peut que vous deviez respecter certains délais pour conserver votre couverture santé ou vos remboursements. Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German
Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag oder Ihren Beihilfeleistungen. Prüfen Sie die Mitteilung auf wichtige Termine. Möglicherweise müssen Sie bis zu einem bestimmten Datum Maßnahmen ergreifen, um Ihre Beihilfeleistungen oder Kostenzuschüsse aufrechtzuerhalten. Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Hindi
इस सूचना में आपके आवेदन या लाभों के बारे में महत्वपूर्ण जानकारी है। महत्वपूर्ण तिथियाँ देखें। अपने लाभ बनाए रखने या लागत का प्रबंध करने के लिए, आपको निश्चित तिथियों तक कार्रवाई करने की ज़रूरत हो सकती है। आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Igbo
Ọkwa a nwere ozi dị mkpa gbasara akwụkwọ anamachọihe ma ọ bụ elele gị. Chọgharịa ụbọchị ndi dị mkpa. Ị nwere ike ịme ihe n'ụfọdụ ụbọchị iji dowe elele gị ma ọ bụ jikwaa ọnụego. Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Korean
이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Russian
Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться выполнение определенных действий в указанные сроки. Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте.
(TTY/TDD: 711)
Tagalog

May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Urdu

یہ نوٹس آپ کی درخواست یا فائدوں کے بارے میں اہم معلومات پر مشتمل ہے۔ اہم تاریخیں دیکھیے۔ اپنے فائدوں یا لاگتوں کو منظم کرنےکے لیے آپ کو بعض تاریخوں پر اقدام کرنے کی ضرورت ہوسکتی ہے۔ آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (TTY/TDD:711)

Vietnamese

Thông báo này có thông tin quan trọng về đơn đang ký hoặc quyền lợi bảo hiểm của quý vị. Hãy tìm các ngày quan trọng. Quý vị có thể cần phải có hành động trước những ngày nhất định để duy trì quyền lợi bảo hiểm hoặc quản lý chi phí của mình. Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yoruba

Àkíyèsí yìí ní ìwífún pàtàkì nípa ìbéèrè tàbí àwọn ànfàní rẹ. Wá déètì pàtàkì. O le ní láti gbé ìgbésẹ̀ ní déètì kan pàtó láti tọ́jú àwọn ànfàní tàbí ṣàkóso iye owó rẹ. O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)

WHO TO CONTACT FOR ASSISTANCE

Medical, Dental, Vision and Hearing Coverage Claims Administrator

Anthem Blue Cross and Blue Shield

Member Services	800-552-2682
Web Address	**www.anthem.com/cova** Select “Line of Duty Act (LODA) Medicare Primary”
Mailing Address	Anthem Blue Cross and Blue Shield Member Services P. O. Box 27401 Richmond, VA 23279
Appeals Address for Claims Processed by Anthem (not including claims adjudicated by Medicare)	Anthem Blue Cross and Blue Shield Attn: Corporate Appeals Department P. O. Box 27401 Richmond, VA 23279
ID Card Order Line	866-587-6713

Outpatient Prescription Drug Coverage

Express Scripts Medicare	Customer Service - 1-800-572-4098 TTY users - 1-800-716-3231 **www.Express-Scripts.com**

Plan and Benefits Administration

Department of Human Resource Management

Telephone	888-642-4414 (indicate that you are calling regarding LODA)
Web Address	**www.dhrm.virginia.gov**
E-Mail	**LODA@dhrm.virginia.gov**

USING YOUR BENEFITS TO THE BEST ADVANTAGE

Because this Plan coordinates Medicare-covered medical benefits with Original Medicare (the primary payer), you must also be enrolled in both Medicare Parts A and B to receive full benefits. If you are not enrolled in Medicare Parts A and B, this Plan will not pay for any services that should have been paid by Medicare had you been enrolled. If you are enrolled in Medicare Advantage (HMO, PPO, Special Needs, Private Fee-for-Service) rather than Original Medicare, medical services you receive will not be covered by this Plan.

Medicare Participating Providers

To help save on your medical expenses, use Medicare Participating Providers whenever possible for Medicare-covered services. Hospitals and doctors who participate in Medicare agree to accept Medicare's Allowable Charge for covered services as payment in full. Non-Medicare-Participating Providers may charge you more than the Medicare-approved amount. Contact Medicare for more information.

To find out if your doctors and suppliers participate in Medicare, visit **www.medicare.gov/physician** or **www.medicare.gov/supplier**, call 1-800-MEDICARE, or ask your doctors, Providers, or suppliers if they participate.

Filing Claims

In most instances, Medicare Participating Providers will file claims for your Secondary Coverage, or claims will automatically cross over after Medicare's primary benefit is paid. However, if they do not, you must file the secondary claim yourself. When you file your secondary claim, the Medicare Summary Notice must be sent to the Claims Administrator with your claim.

COORDINATION OF MEDICARE AND THE LODA PLAN – MEDICARE PRIMARY

These charts contain only basic information about Medicare coverage. They are intended to highlight how the LODA Plan – Medicare Primary supplements Original Medicare coverage.

Part A Services	**Medicare**
Hospital Inpatient	• Pays up to 60 days of Medically Necessary services, except Part A Hospital deductible • Pays up to an additional 30 days, except daily coinsurance • If more than a 90-day Hospital stay, can pay up to 60 Medicare Lifetime Reserve days, except daily coinsurance • No payment for more than a 90-day Hospital stay if no Medicare Lifetime Reserve Days remain or if You choose not to use them
Skilled Nursing Facility	• Pays 100% for 20 days at a Medicare-certified Skilled Nursing Facility • Pays up to an additional 80 days at a Skilled Nursing Facility, except daily coinsurance • Medicare does not pay for more than 100 days at a Skilled Nursing Facility in a Benefit Period
Part B Services	
Physician and Other Services	• Generally pays 80% of Medicare-Approved Charges for services such as doctor's care and Outpatient Physical or Occupational Therapy (within limits) – Certain screenings and wellness/preventive services are covered at no cost-see your "Medicare and You" publication for more information. • An annual deductible may apply
Part D Services	
Prescription Drug Coverage	• Pays a benefit based on the specific Part D Plan in which the beneficiary is enrolled.
Other Services	
Routine Vision	• Not covered
Routine Dental Benefits	• Not covered
Routine Hearing Benefits	• Not covered
Out-of-Country and Major Medical Services	• Not covered
At-Home Recovery Care and Visits	• Not covered

COORDINATION OF MEDICARE AND THE LODA PLAN – MEDICARE PRIMARY

Part A Services	LODA Plan – Medicare Primary
Hospital Inpatient (medical)	• Pays Medicare Part A deductible except for first $100 • Pays Medicare Part A coinsurance • Pays 100% of the Allowable Charge for eligible expenses for an additional 365 days (requires use of Medicare Lifetime Reserve Days)
Skilled Nursing Facility	• Pays Medicare Part A coinsurance (days 21-100) • Pays above coinsurance amount for an additional 80 days per Medicare Benefit Period
Part B Services	
Physician And Other Services	• Does not pay Medicare Part B deductible, but does pay Part B coinsurance
Part D Services	
Prescription Drug Coverage	• Enhanced Medicare Part D plan (see page 28 for details)
Other Services	
Routine Vision Benefits	• Annual Routine exam/frames and/or lenses (see page 38 for details)
Routine Dental Benefits	• Diagnostic/Preventive, basic and major dental care (see page 32 for details)
Routine Hearing Benefits	• Pays for one routine hearing test every 48 months, except for $40 copayment • Pays up to $1,200 toward the cost of hearing aids and supplies every 48 months
Out-of-Country and Major Medical Services	**For Out-of-Country services only:** • Pays 80% of Allowable Charge after You pay $250 Calendar Year deductible • $250,000 lifetime maximum applies (see page 24 for details)
At-Home Recovery Care and Visits	• Pays up to $40 per visit, not to exceed $1,600 each Calendar Year and 7 visits each week

GENERAL RULES GOVERNING BENEFITS

1) When A Charge Is Incurred
You incur the charge for a service on the day you receive the service.

2) When Benefits Start
Your benefits start on your Effective Date. No benefits will be provided for any charges you incur before that date.

3) Services Must Be Medically Necessary
Benefits will be denied if the Claims Administrator determines, in its sole discretion, that care is not Medically Necessary. Medicare adjudicates medical necessity when Medicare is the primary payer.

4) When Benefits End
Benefits will not be provided for charges you incur after your coverage ends. There is one exception. If you are an Inpatient on the day your enrollment ends, the services to which you would have been entitled under the Hospital Services and Skilled Nursing Facility Services sections will be covered until your date of discharge for that admission. These benefits will be provided only to the extent they would have been provided had your enrollment not ended (including applicable coordination of benefits).

5) Defining Services
For services covered under this Plan but not covered by Medicare when classifying a particular service, the Claims Administrator will use the most recent edition of a book published by the American Medical Association entitled Current Procedural Terminology (CPT). The Allowable Charge for a procedure will be based on the most inclusive code, and the Claims Administrator alone will determine the most inclusive code. No benefits will be provided for lesser included procedures or for procedures which are components of a more inclusive procedure.

6) Payment To Participating Providers
For services covered under this Plan but not covered by Medicare, the Claims Administrator pays the Allowable Charge which remains after your copayment, coinsurance or deductible.

When an Enrollee receives services from a Participating Provider in the Claims Administrator’s network, the Claims Administrator will make payment for these services directly to the Provider. But, if the Enrollee has already paid the Provider and the Provider tells the Claims Administrator to do so, the Claims Administrator will pay the Enrollee. A Provider who participates in one of the Claims Administrator's Networks will accept the Claims Administrator's allowance as payment in full for that service. Payment by the Claims Administrator will relieve the Claims Administrator and the Plan of any further liability for the service.

7) Non-Participating Provider Payments
When a Participant receives services from a Non-Participating Provider (not in the Claims Administrator’s network) for services covered under this plan but not covered by Medicare, the Claims Administrator may choose to make payment directly to the Enrollee or, at the Claims Administrator's sole option, to any other person responsible for payment of the Provider's charge. Payment will be made only after the Claims Administrator has received

an itemized bill and the medical information the Claims Administrator decides is necessary to process the claim. The Enrollee will also be responsible for the difference between the Plan's allowance and the Provider's charge. Payment by the Claims Administrator will relieve it and the Plan of any further liability for the Non-Participating Provider's services.

8) Appeals

Complaint and Appeal Process (not including complaints or appeals regarding Medicare benefits)

You have access to both a complaint process and an appeal process. Should you have a problem or question about your Plan, the Claims Administrator's Member or Customer Services Department will assist you. Most problems and questions can be handled in this manner. You may also file a written complaint or appeal. Complaints typically involve issues such as dissatisfaction about your Plan's services, quality of care, the choice of and accessibility to Providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by your Plan. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

Complaint Process

Upon receipt, your complaint will be reviewed and investigated. You will receive a response within 30 calendar days of receipt of your complaint. If we are unable to resolve your complaint in 30 calendar days, you will be notified on or before calendar day 30 that more time is required to resolve your complaint. We will then respond to you within an additional 30 calendar days.

Important: Written complaints or any questions concerning your coverage, excluding those regarding Medicare benefits, may be filed at the address shown in the "Who to Contact for Assistance" section of this summary plan description.

Appeal Process

Your Plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider a coverage decision (not including Medicare coverage) you find unacceptable. There are two types of appeals:

- Claims Administrator appeals are requests to reconsider coverage decisions of pre-service or post-service claims. A separate expedited emergency appeals procedure is available to provide resolution within one business day of the receipt of a complaint or appeal concerning situations requiring immediate medical care. All appeals to a Claims Administrator must be exhausted before an appeal can be made to the Department of Human Resource Management (DHRM).
- After Claims Administrator appeals are exhausted, you may request of DHRM an appeal process that includes an impartial clinical review by an independent, external reviewer of the final coverage decision made by the Claims Administrator. Additionally, other Plan related issues may be appealed to DHRM. More information about this appeal may be found in the Final DHRM Appeal Process of this section.

How to appeal a coverage decision

To appeal a coverage decision, please send a written explanation to the Claims Administrator's address of why you feel the coverage decision was incorrect. Alternatively, the Claims Administrator will accept a verbal request for appeal by calling a Member/Customer Services representative. You may provide any comments, documents or information that you feel the Claims Administrator should consider when reviewing your appeal. Please include with the explanation:

- the patient's name, address and telephone number;
- Your identification and group number (as shown on Your identification card); and
- the name of the health care professional or facility that provided the service, including the date and description of the service provided and the charge.

You must file your appeal within 15 months of the date of service or 180 days from the date you were notified of the adverse benefit determination, whichever is later.

How the Claims Administrator will handle Your appeal

In reviewing your appeal, the Claims Administrator will take into account all the information you submit, regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by a practitioner who holds a non-restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as one who typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

The Claims Administrator will resolve and respond in writing to your appeal within the following time frames:

- for pre-service claims, the Claims Administrator will respond in writing within 30 days after receipt of the request to appeal;
- for post-service claims, the Claims Administrator will respond in writing within 60 days after receipt of the request to appeal; or
- for expedited emergency appeals, the Claims Administrator will respond orally within one working day after receipt from the Participant or treating Provider of the request to appeal, and will then provide written confirmation of its decision to the Participant and treating Provider within 24 hours thereafter.

When the review of your appeal by the Claims Administrator has been completed, you will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the Plan provision(s) on which the determination is based. You will also be entitled to receive, upon request and at no charge, the following:

- reasonable access to, and copies of, all documents, records, and other information relevant to the appeal
- any rule, guideline, protocol or criterion relied upon in the coverage decision(s);

- the explanation of the scientific or clinical judgment as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- the identification of medical or vocational experts whose advice was obtained by the Plan in connection with the claimant's adverse decision, whether or not the advice was relied upon.

Final DHRM Appeal Process

The Department of Human Resource Management does not accept claim appeals for:

- specific coverage exclusions listed in this summary plan description. However, denials of claims or coverage for services involving medical necessity (e.g., Experimental/ Investigational procedures) can be appealed;
- matters in which the sole issue is disagreement with policies, rules, regulations, contract or law;
- amounts above the Allowable Charge which are billed by a Non-Participating Provider when the Allowable Charge has already been paid,
- Medicare payments or claim denials.

In these cases, the Claims Administrator's or Medicare's decision is final.

Except as listed above, to further appeal the final coverage decision made by your Plan through its internal appeal process, you must submit to the Director of the Department of Human Resource Management, in writing within 60 days of your Plan's denial, the following:

- your full name;
- your identification number;
- the date of the service;
- the name of the Provider for whose services payment was denied; and
- the reason you think the claim should be paid.

You are responsible for providing DHRM with all information necessary to review the denial of your claim. The Department will ask you to submit any additional information you wish to have considered in this review, and will give you the opportunity to explain, in person or by telephone, why you think the claim should be paid. Claims denied by the Plan, not by Medicare, due to such things as policy or eligibility issues will be reviewed by the director of DHRM. Claims denied because the treatment provided was considered not Medically Necessary will be referred to an independent medical review organization.

For issues of Medical Necessity, the medical review organization will examine the final denial of claims or treatment authorizations to determine whether the decision is objective, clinically valid, and comparable with established principles of health care. The decision of the medical review organization will:

- be in writing;
- contain findings of fact as to the material issues in the case and the basis for those findings; and
- be final and binding if consistent with law and policy.

With all Plan-related appeals to DHRM, if after review, the denial is upheld, that denial is final.

Beyond any final denial, you may appeal that determination as per the provisions of the Administrative Process Act within 30 days of the final DHRM determination. You may download an external appeals form at **www.dhrm.virginia.gov**.

9) Coordination Of Benefits

This Plan is designed to supplement Medicare. If you are enrolled in this Plan, Medicare will generally pay before this coverage for all Medicare-covered services. However, you are required to notify Your Claims Administrator if you are enrolled under another Health Benefit Plan in addition to Medicare. The following rules apply to coordination of benefits for services that are covered under this Plan but are not covered by Medicare (including, but not limited to routine dental and vision benefits).

Primary Coverage and Secondary Coverage

When a Covered Person is also enrolled in another group health Plan, one coverage will be primary and one will be secondary. The decision of which coverage will be primary or secondary is made using the order of benefit determination rules. Highlights of these rules are described below:

- If the other coverage does not have COB rules substantially similar to Your Health Plan's, the other coverage will be primary.
- If a Covered Person is enrolled as the named insured under one coverage and as a dependent under another, generally the one that covers him or her as the named insured will be primary.
- If a Covered Person is the named insured under both coverages, generally the one that covers him or her for the longer period of time will be primary.
- If the Covered Person is enrolled as a dependent child under both coverages (for example, when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the Calendar Year will be the primary.
- Special rules apply when a Covered Person is enrolled as a dependent child under two coverages and the child's parents are separated or divorced. Generally, the coverage of the parent or step-parent with custody will be primary. However, if there is a court order that requires one parent to provide health care for the child, that parent's coverage will be primary. If there is a court order that states that the parents share joint custody without designating that one of the parents is responsible for medical expenses, the coverage of the parent whose birthday falls earliest in the Plan Year will be primary.

When Your Health Plan is the Primary Coverage, it pays first. When your Health Plan is the Secondary Coverage, it pays second as follows:

- The Claims Administrator calculates the amount your Health Plan would have paid if it had been the Primary Coverage, then coordinates this amount with the primary Plan's payment. The combination of the two will not exceed the amount your Health Plan would have paid if it had been your Primary Coverage.
- Some Plans provide services rather than making a payment (i.e., a group model HMO). When such a Plan is the Primary Coverage, Your Health Plan will assign a reasonable cash value for the services and that will be considered the primary Plan's payment. Your Health Plan will then coordinate with the primary Plan based on that value.
- In no event will your Health Plan pay more in benefits as Secondary Coverage than it would have paid as Primary Coverage.

The benefits of the Health Benefit Plan which covers the person as a working Employee (or the Employee's dependent) will be determined before those of the Health Benefit Plan which covers the person as a laid off or retired Employee (or the Employee's dependent).

The benefits of the Health Benefit Plan which covers the person as an Employee (or the Employee's dependent) will be determined before those of the Health Benefit Plan which covers the person under a right of continuation pursuant to federal or state law.

If you receive services that are covered under these Plans but not covered by Medicare and, under the priority rules, this Plan is the Primary Coverage, You will receive unreduced benefits for covered services to which you are entitled under this Plan.

If you receive services that are covered under these Plans but not covered by Medicare but you have other coverage that is primary, based on the above rules, your benefits will be reduced so that the total benefit paid under this Plan and the other Health Benefit Plan will not exceed the benefits payable for covered services under this Plan absent the other Health Benefit Plan. Benefits that would have been paid if you had filed a claim under the Primary Coverage will be counted and included as benefits provided. In a Calendar Year, benefits will be coordinated as claims are received.

At the option of the Claims Administrator, payments may be made to anyone who paid for the coordinated services you received. These benefit payments by the Claims Administrator are ones which normally would have been made to you or on your behalf to a facility or Provider. The benefit payments made by the Claims Administrator will satisfy the obligation to provide benefits for covered services.

If the Claims Administrator provided Primary Coverage and discovers later that it should have provided Secondary Coverage, the Claims Administrator has the right to recover the excess payment from you or any other person or organization. If excess benefit payments are made on your behalf, you must cooperate with the Claims Administrator in exercising its right of recovery.

You are obligated to supply the Claims Administrator all information needed to administer this section. This must be done before you are entitled to receive benefits under this Plan. Further, you agree that the Claims Administrator has the right to obtain or release information about covered services or benefits you have received. This right will be used only when working with another person or organization to settle payments for coordinated services. Your prior consent is not required.

10) Notice From The Claims Administrator To You

A notice sent to you by the Claims Administrator is considered "given" when delivered to DHRM, as your Plan and Benefits Administrator, at the address listed in the Claims Administrator's records. If the Claims Administrator must contact you directly, a notice sent to you by the Claims Administrator is considered "given" when mailed to the Enrollee at the Enrollee's address listed in the Claims Administrator's records. Be sure the Claims Administrator has the Enrollee's current mailing address.

11) Notice From You To The Claims Administrator

Notice by you or DHRM is considered "given" when delivered to the Claims Administrator. The Claims Administrator will not be able to provide assistance unless the Enrollee's name and identification number are in the notice.

12) Assignment of Payment

You may not assign the right to receive payment for covered services. Prior payments to anyone, whether or not there has been an assignment of payment, will not waive or restrict your Plan's right to make future payments to a covered person or any other person. This provision does not apply to dentists or oral surgeons. Once covered services are rendered by a Provider, your Plan will not honor requests not to pay the claims submitted by the Provider. Your Plan will have no liability to any person because it rejects the request.

13) Fraud and Abuse

If you suspect fraud or abuse involving a claim, please notify the Claims Administrator by calling Member Services to report the matter for investigation.

INSTITUTIONAL SERVICES
HOSPITAL SERVICES

Services Which Are Eligible for Reimbursement

1) Medicare Part A services.

2) If you need Inpatient care beyond the 90-day Medicare Benefit Period (except for Medicare Lifetime Reserve Days):

- Bed and board in a Semi Private Room, including general nursing services and special diets. A bed in an intensive care unit is eligible for reimbursement for critically ill patients. Your Plan covers the charge for a private room if you need a private room because you have a highly contagious condition; you are at greater risk of contracting an infectious disease because of your medical condition; or if the Hospital only has private rooms. Otherwise, you have coverage for a Semi-Private Room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to any Copayment or Coinsurance that may apply.
- Customary ancillary services for Inpatient stays, including operating rooms, medications, oxygen and oxygen tents, dressings and casts, anesthesia, transfusions, Diagnostic and Therapy Services, emergency room services leading directly to admission or which are rendered to a patient who dies before being admitted, ambulance services for transportation between local Hospitals when Medically Necessary, and routine nursery care of a newborn as part of a mother's covered maternity service.

Conditions for Reimbursement

Services must be:

- approved by Medicare for all Medicare-covered services;
- prescribed by a Provider licensed to do so; and
- determined to be Medically Necessary by the Claims Administrator for Inpatient services beyond the 90-day Medicare Benefit Period (or Medicare Lifetime Reserve Days).

Special Limits

1) You are limited to 455 Days of Inpatient Care in a Hospital per Medicare Benefit Period (90 Medicare days plus 365 days under your Plan, not including your 60 Medicare Lifetime Reserve Days).

2) You are limited to 60 additional Days of Inpatient Care in a Hospital under Medicare during your lifetime (your Medicare Lifetime Reserve Days)

3) You must use all Medicare Inpatient Hospital coverage, including Medicare Lifetime Reserve Days, before exercising the 365 additional days under your Plan.

4) You are entitled to 190 Days of Inpatient Care in a Hospital designated by Medicare as a

psychiatric hospital during your lifetime.

5) The amounts to which you are entitled under this section will not increase even if:

- You were not enrolled in Part A of Medicare; or
- The Hospital Facility providing services did not participate with Medicare at the time you received care.

Reimbursement

The Claims Administrator pays:

- The Medicare Part A deductible less $100 for days 1-60 per Medicare Benefit Period.
- The Medicare Part A coinsurance for days 61-90 per Medicare Benefit Period.
- 100% of the Allowable Charge for days 91-455 for services and supplies listed in item 2 of Services Which Are Eligible for Reimbursement in this section, not including the 60 Medicare Lifetime Reserve Days.
- The Medicare Part A coinsurance for 60 additional Days of Inpatient Care in a Hospital during your lifetime (Medicare Lifetime Reserve Days must be used before exercising the additional 365 days under your Plan).
- The Allowable Charge for the first three pints of blood if required as an Inpatient (not covered by Medicare).

Deductible

You pay $100 of the Medicare Part A deductible for days 1-60 per Medicare Benefit Period.

INSTITUTIONAL SERVICES
SKILLED NURSING FACILITY SERVICES

Services Which Are Eligible for Reimbursement

Medicare Part A services.

Conditions for Reimbursement

Services must be:

- approved by Medicare for all Medicare-covered services;
- prescribed by a Provider licensed to do so; and
- for services covered under these Plans but not covered by Medicare (days 101-180), services must be determined to be Medically Necessary by the Claims Administrator.

Special Limits

1) You are entitled to 180 Days of Inpatient Care in a Skilled Nursing Facility per Medicare Benefit Period. Medicare covers 100 days.

2) The amounts to which you are entitled under this section will not increase even if:

- You were not enrolled in Part A of Medicare; or
- the Skilled Nursing Facility providing services did not participate with Medicare at the time you received care.

Reimbursement

1) Medicare pays 100% for days 1-20 in a Skilled Nursing Facility per Medicare Benefit Period.

2) The Claims Administrator pays the Medicare Part A coinsurance for days 21-100 in a Skilled Nursing Facility per Medicare Benefit Period.

3) The Claims Administrator pays an amount equal to the days 21-100 Medicare part A coinsurance for days 101-180 in a Skilled Nursing Facility per Medicare Benefit Period.

PROFESSIONAL AND OTHER PART B SERVICES

Services Which Are Eligible for Reimbursement

Medicare Part B services.

Conditions for Reimbursement

Services must be:

- approved by Medicare for all Medicare-covered services; and
- performed or prescribed by a Provider licensed to do so.

Special Limitations

The amounts to which you are entitled under this section will not increase even if:

- You were not enrolled in Part B of Medicare; or
- the person or facility that furnished you a service did not participate with Medicare at the time you received care.

Reimbursement

The Claims Administrator pays the Medicare Part B coinsurance.

Deductible

You pay the Medicare Part B deductible.

ROUTINE HEARING SERVICES

Services Which Are Eligible for Reimbursement

1) Routine hearing examination.

2) Hearing aids and other related hearing aid services and supplies except disposable hearing aids. Examples of covered supplies necessary for the use of the hearing aid include ear molds, ear buds (not required for all hearing aids), filter and batteries.

Conditions for Reimbursement

1) Hearing services must be:

- billed for by a Provider in private practice such as an audiologist or doctor of medicine;
- services which the Provider is licensed to render; and
- submitted with a routine hearing diagnosis or the service will be considered under the Medical benefit.

2) Hearing tests and hearing aids do not have to be provided by an in-network Provider. Services are considered at the same benefit level regardless of Provider network status. However, you may be held responsible for any amounts above the Allowable Charge up to the out-of-network Provider's charge.

Special Limits

1) Routine hearing exam is available once every 48 months.

2) Hearing aids and other related hearing aid services and supplies are available once every 48-months.

3) The 48-month count starts the month you purchase your hearing aid(s) or related hearing services.

4) Reimbursement is limited to $1,200 for the hearing aid and first set of batteries.

5) Services required by your employer as a condition of employment or rendered through a Medical department, clinic, or other similar services provided or maintained by the employer are excluded.

6) Disposable hearing aids, even if by prescription, are excluded.

Reimbursement

The Claims Administrator pays the remaining Allowable Charge after your Copayment for the routine hearing examination.

Copayment:

You pay routine hearing examination copayment of $40

You pay any remaining cost for hearing aids and other hearing supplies after the Claim Administrator's Reimbursement of $1,200.

AT-HOME RECOVERY SERVICES

Services Which Are Eligible for Reimbursement

1) At-Home Recovery Visits for short-term, at-home assistance with the activities of daily living rendered by a care Provider are covered if you are recovering from a sickness, injury, or surgery.

Activities of daily living include any of the following:

- bathing
- dressing
- personal hygiene
- transferring (for example, wheelchair to bed)
- eating
- ambulating
- assistance with drugs that are normally self-administered
- changing bandages or other dressings

Conditions for Reimbursement

1) Your attending Physician must certify that the specific type and number of At-Home Recovery services are necessary because of a condition for which Medicare approves an at-home care treatment plan. The number of At-Home Recovery Visits cannot exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.

2) Services must be rendered in your home, which means your place of residence, if such a place would qualify as a residence for home health care services covered by Medicare. A Hospital or Skilled Nursing Facility is not a home.

3) You must receive At-Home Recovery Visits:

- while you are receiving Medicare-approved home care services, or
- no more than eight (8) weeks after the date of the last Medicare-approved home health care visit.

Special Limits

1) Benefits are limited to a maximum of seven (7) At-Home Recovery Visits in any one week and $1,600 in each Calendar Year.

2) Each consecutive four hours in a 24-hour period of services provided by a care provider is one visit.

3) Benefits are not available for:

- home care visits paid for by Medicare or other government programs; or
- care provided by family members, unpaid volunteer or others who are not care Providers.

Reimbursement

1) The Claims Administrator pays the charges up to $40 per home visit up to $1,600 per Calendar Year.

Copayments

You pay any charges greater than the above limitations.

OUT-OF-COUNTRY MAJOR MEDICAL SERVICES

The following services are covered only when they are received out of the country.

Services Which Are Eligible for Reimbursement

1) Bed and board in a Semi Private Room, including general nursing services and special diets. A bed in an intensive care unit is eligible for reimbursement for critically ill patients. Your Plan covers the charge for a private room if you need a private room because you have a highly contagious condition; you are at greater risk of contracting an infectious disease because of your medical condition; or if the Hospital only has private rooms. Otherwise, you have coverage for a Semi-Private Room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to any Copayment or Coinsurance that may apply.

2) Customary ancillary services for Inpatient stays, including operating rooms, medications, oxygen and oxygen tents, dressings and casts, anesthesia, transfusions, blood, blood plasma, blood derivatives, blood volume expanders, and professional donor fees, Diagnostic and Therapy Services, ambulance services for transportation between local Hospitals when Medically Necessary, and routine nursery care of a newborn as part of a mother's covered maternity service.

3) Outpatient Hospital services including Diagnostic Services, Therapy Services, and Inpatient ancillary services when unavailable in an Inpatient facility.

4) Inpatient and Outpatient Medical, Surgical, Maternity, Anesthesia, and Psychiatric Services.

5) Outpatient Diagnostic Services.

6) Outpatient Therapy Services. Under this Major Medical Services section, services may be furnished and billed for by a registered occupational therapist, a certified speech therapist, physical therapist or a certified inhalation therapist.

7) Dental services (non-routine). Your Plan also provides coverage for the following non-routine dental services through the Claims Administrator medical benefits.

- Medically Necessary dental services resulting from an accidental injury, provided that you seek treatment within 60 days after the injury. You must submit a treatment plan from your dentist or oral surgeon for prior approval by Anthem;
- Medically Necessary dental services when required to diagnose or treat an accidental injury to the teeth if the accident occurs while you are covered under the plan. These services and appliances are covered for adults if rendered within a two-year period after the accidental injury. The two-year restriction may be waived for children under age 18. Actual treatment may be delayed if tooth/bone maturity is in question and standard industry protocols are followed. However, a treatment plan must be filed within six months of the accident and treatment must be completed within two years of active treatment commencement and prior to age 20. For the waiver to be granted, continuous coverage under the Plan is required;

- the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face;
- dental services and dental appliances furnished when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; and
- dental services to prepare the mouth for Radiation Therapy to treat head and neck cancer

8) Emergency services in an emergency room, if not covered under Hospital Services.

9) Prescribed services performed by a licensed private duty nurse.

10) The rental of prescribed durable medical equipment for temporary therapeutic use.

11) The following types of prescribed prosthetic devices, orthopedic appliances, and orthopedic braces including the fitting, adjustment, and repair are eligible for reimbursement:

a. Artificial arms and legs, including accessories
b. Leg braces, including attached shoes
c. Built up shoes for post polio patients
d. Arm braces
e. Back braces and neck braces
f. Surgical supporters
g. Head halters

12) Prescribed medical supplies are eligible for reimbursement, including:

a. Sterile dressings for conditions such as burns or cancer
b. Catheters
c. Colostomy bags
d. Oxygen
e. Syringes, needles and related medical supplies required by Your medical conditions

13) The following prescribed eyeglasses or contact lenses are eligible for reimbursement:

a. Eyeglasses or contact lenses which replace human lenses lost as the result of intra ocular surgery or injury to the eye
b. "Pinhole" glasses used after surgery for a detached retina
c. Lenses used instead of surgery, such as:
  i. Contact lenses for the treatment of infantile glaucoma
  ii. Corneal or scleral lenses in connection with keratoconus
  iii. Scleral lenses to retain moisture when normal tearing is not possible or is not adequate
  iv. Corneal or scleral lenses to reduce a corneal irregularity (other than astigmatism)

A maximum of one set of eyeglasses or one set of contact lenses will be covered for Your original prescription or for any change in your original prescription. Examination and

replacement for a prescription change are covered only when the change is due to the condition for which you needed the original prescription.

14) Ambulance services are eligible for reimbursement when used locally to or from a Covered Facility or Provider's office.

Conditions for Reimbursement

1) With respect to private duty nursing services, only services by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) are covered. Also,

- these services must be Medically Necessary;
- the nurse may not be a relative or member of your family;
- Your Provider must explain why the services are required; and
- Your Provider must describe the Medically Skilled Service provided.

2) For durable medical equipment, Your Provider must, upon request, explain why the equipment is needed and how long it will be used.

3) For coverage of ambulance services:

- the trip to the facility or office must be to the nearest one recognized by the Claims Administrator as having services adequate to treat your condition;
- the services You receive in that facility or Provider's office must be covered services; and
- if the Claims Administrator requests it, the attending Provider must explain why you could not have been transported in a private car or by any other less expensive means.

Special Limits

1) The Major Medical Services specifically covered in this section are not eligible for reimbursement if covered under any other section of this summary plan description, including Medicare benefits. The Claims Administrator will pay only once for a service. Services covered in this section and not covered by other sections of this summary plan description must be medically necessary as determined by the Claims Administrator.

2) The Major Medical Services discussed in this section must be rendered by a Hospital or Provider outside of the United States, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa. They must be prescribed or performed by a Provider licensed to do so, and Medically Necessary.

3) Routine dental, vision, or hearing services and Outpatient prescription drug services are not available for reimbursement under Major Medical Services.

4) The following and similar items are not eligible for reimbursement as durable medical equipment:

- exercise equipment
- air conditioners
- dehumidifiers and humidifiers
- whirlpool baths

- handrails
- ramps
- elevators
- telephones
- adjustments made to a vehicle

5) Furthermore, the Claims Administrator will not pay for any other equipment which has both a non-therapeutic and therapeutic use. The Claims Administrator will pay for the least expensive item of equipment required by your medical condition. If the Claims Administrator determines that purchase of the durable medical equipment is less expensive than rental, or if the equipment cannot be rented, the Claims Administrator may approve the purchase as a covered service. If the equipment cannot be rented, the Claims Administrator may cover the purchase price.

6) Corrective shoes and shoe inserts are not eligible for reimbursement.

7) No claim for Major Medical Services will be paid if the Claims Administrator receives it more than one year after the end of the Calendar Year in which the service was rendered.

8) The lifetime maximum benefit for Major Medical Services is $250,000 per Participant. The Claims Administrator will annually reinstate the amount the Claims Administrator paid for Your Major Medical Services during the immediately preceding Major Medical Benefit Period, not to exceed $2,000 per Major Medical Benefit Period.

9) When You incur $1,200 in Out-of-Pocket Expenses in one Major Medical Benefit Period for out-of-country Major Medical Services, the Claims Administrator will pay your Out-of-Pocket Expenses for any other covered Major Medical Services You receive during the remainder of that Major Medical Benefit Period.

Reimbursement

The Claims Administrator pays the remaining Allowable Charge minus your deductible and coinsurance.

Deductible

You pay $250 per Enrollee per Major Medical Benefit Period (Calendar Year).

Coinsurance

After you pay the deductible, you pay 20% of the Allowable Charge (except as noted in paragraph 9).

OUTPATIENT PRESCRIPTION DRUG BENEFITS

Following are the provisions of your Medicare prescription drug plan. Consult your Medicare Part D Evidence of Coverage (provided by your Medicare Part D Claims Administrator) for additional information.

Formulary - Generally, only drugs included on the plan's Formulary will be covered. (However, participants may apply for a Formulary Exception by requesting a Coverage Determination/Decision-see Your Evidence of Coverage for complete information).

To determine whether a drug is included on the plan's Formulary and its coverage tier, contact your Medicare Part D Claims Administrator's Customer Service or go to its web site. Some of the drugs covered under this plan have coverage limits. This could include restricting the amount of medication covered within a period of time, requiring Prior Authorization, or requiring Step Therapy.

If a drug is removed from the Formulary or moved to a higher cost-sharing tier, or if Prior Authorizations, Quantity Limits and/or Step Therapy restrictions are added after January 1, the start of the plan year, and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the plan year. However, if a Brand Name Drug is replaced with a new Generic drug, or the Formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change during the plan year. You will be notified of the change at least 60 days before the date that the change becomes effective, or you will be provided with a 60-day supply at the pharmacy (unless the drug is removed from the Formulary because it has been recalled from the pharmacies, in which case the drug will be removed immediately and affected participants will be notified as soon as possible). Please refer to Your Welcome Kit or Annual Notice of Changes for additional information.

Drugs that are excluded for Medicare Part D coverage, as determined by Medicare, will not be included on the Formulary.

Tier - Drugs included on the Formulary are placed in tiers. The co-payment or coinsurance amount that you pay for any covered drug depends on its tier.

The amounts designated by Medicare to define each coverage stage will be provided to you in your Annual Notice of Changes booklet and Benefit Overview.

Coverage Stages

Deductible Stage - A plan year (January 1-December 31) deductible, as defined in your Annual Notice of Changes and Benefit Overview, will apply to all covered drugs except Generics. There will be no deductible for covered Generics. Once the deductible has been met, the applicable co-payment or coinsurance will apply.

Initial Coverage Stage – Once your deductible has been met for covered Brand Name Drugs (and immediately for covered Generics), your co-payments/coinsurance will remain as follows until your total covered drug cost reaches the coverage gap level, as defined in your Annual Notice of Changes and Benefit Overview.

Initial Coverage Stage - Covered Tier 1 (Generic) Drugs	**Co-payment effective July 1, 2017**
Per one-month (up to 34-day) supply at a retail Network Pharmacy	$7
Per up to a 90-day supply through the home delivery service	$7

Initial Coverage Stage - Covered Tier 2 (Preferred Brand) Drugs	**Co-payment effective July 1, 2017**
Per one-month (up to 34-day) supply at a retail Network Pharmacy	$25
Per up to a 90-day supply through the home delivery service	$50

Initial Coverage Stage - Covered Tier 3 (Non-Preferred Brand) Drugs	**Coinsurance effective July 1, 2017**
Per one-month (up to 34-day) supply at a retail Network Pharmacy	You pay 75%
Per up to a 90-day supply through the home delivery service	You pay 75%

Initial Coverage Stage - Covered Tier 4 (Specialty) Drugs	**Coinsurance effective July 1, 2017**
Per one-month (up to 34-day) supply at a retail Network Pharmacy	You pay 25%
Per up to a 90-day supply through the home delivery service	You pay 25%

If your doctor prescribes less than a full month's supply, you may not have to pay the cost of an entire month's supply - Typically, you pay a copayment or coinsurance to cover a full month's supply (up to a 34-day supply) of a covered drug. However, your doctor can prescribe less than a full month's supply. There may be times when you want to ask your doctor about

prescribing less than a full month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor agrees to prescribe less than a full month's supply, you will not have to pay for the full month's supply for certain drugs. If the drug is in a tier that has a copayment (instead of coinsurance), your copayment will be based on the number of days of the drug that you receive. The amount of copayment you pay each day for a month's supply will be calculated, and you will pay the "daily cost-sharing rate," (If the drug is in a tier that has coinsurance, you will pay a percentage of the total cost of the drug, so you are already paying based on the actual number of days prescribed.)

Coverage Gap Stage – Once your total drug cost exceeds the annual designated level (see your Annual Notice of Changes booklet), you move into the Coverage Gap Stage. In most cases, the amount you pay in the Coverage Gap Stage will be the same as the amount you paid in the Initial Coverage Stage (after any deductible was met). The way that your claim is paid changes. You receive the benefit of the Medicare Coverage Gap Discount Program, which pays 50% of the cost of any covered brand drug manufactured by a program participant. The discount is applied to the cost of the drug, and your co-payment or coinsurance, based on the tier of the drug, is applied. The plan pays the remaining cost. You will not have to pay more than the percentage of total cost designated by Medicare for brand name drugs during this coverage stage. Also, while Generic drugs are not a part of the Medicare Coverage Gap Discount Program, your cost for covered Generics will not exceed the percentage of total cost designated by Medicare for generic drugs during this coverage stage. Both the manufacturer's discount and your out-of-pocket cost will count toward reaching the Catastrophic Coverage Stage.

Catastrophic Coverage Stage– If your annual out-of-pocket drug expense (including Your deductible, co-payments, coinsurance, the contribution from the Medicare Coverage Gap Discount Program, but not including the cost of non-covered or excluded drugs) reaches an amount designated by Medicare (see your Annual Notice of Changes), you will pay the greater of either 5% coinsurance or a designated co-payment for covered Generics, or drugs treated as Generics, and covered Brand Name Drugs. You will remain in this stage for the remainder of the year.

Explanation of Benefits – To help you track your coverage stage, you will receive an Explanation of Benefits (or EOB), which is a statement of what you have spent on your prescription drugs and the total amount that the plan has paid for any month during which you use your coverage.

Medication Therapy Management Programs - These programs are offered at no additional cost for participants who have multiple medical conditions, are taking many prescription drugs, or who have high drug costs. These programs were developed by a team of pharmacists and doctors and help in providing better coverage for participants. They help the plan to ensure that participants are using appropriate drugs to treat their medical conditions and help identify possible medication errors. If you are identified as meeting specific criteria for these programs, you may be contacted. While you are not required to participate, you are encouraged to do so. There is no cost for these programs.

Enrollment in Other Medicare Part D Plans – Medicare does not allow enrollment in more than one Medicare Part D plan at a time. If you are enrolled in the LODA Plan – Medicare Primary and enroll in another (non-LODA) Medicare Part D plan (including any employer plan that receives the Medicare retiree drug subsidy), Medicare will disenroll you from the LODA Medicare Part D plan. This can result in loss of eligibility for LODA coverage since the LODA program does not offer coverage that excludes outpatient prescription drug benefits. If you enroll in a non-LODA Part D plan before you are submitted for LODA Part D coverage, enrollment in the other coverage will generally be terminated.

DENTAL BENEFITS

Services Which Are Eligible for Reimbursement

Diagnostic and Preventive Care

This plan provides coverage for you to see your dentist twice a year for a checkup. This allows your dentist to identify any possible problems and try to prevent cavities and serious dental problems. The following services are generally covered, but in some specific situations, certain exclusions and limitations apply. See “Special Limits” and “Exclusions” in this section.

- Two routine oral evaluations per Calendar Year;
- Two dental prophylaxes (cleanings) per Calendar Year, including scaling and polishing of teeth;
- Space maintainers used to keep teeth from moving into space left when deciduous teeth are pulled – available to Covered Persons under age 16;
- Care for a toothache (palliative emergency care);
- Two sets of bitewing x-rays (two or more films) per Calendar Year (vertical bitewings are considered a full mouth series and allowed once every 36 months.);
- One complete full-mouth x-ray series or a panorex every 36 months (the 36-month count starts the month in which You receive the x-ray series or panorex);
- Two topical fluoride applications per Calendar Year only to Covered Persons under age 19;
- Dental pit/fissure sealants to the unrestored occlusal surface of the first and second permanent molars (limited to one application per tooth). Dental pit/fissure sealants are available only to Covered Persons under age 19;
- Occlusal adjustments; and bite planes or splints for temporomandibular joints disorders;
- Occlusal night guards for demonstrated tooth wear due to bruxism; or occlusal orthotic device for treatment of temporomandibular joint dysfunction (TMJ). Services are limited to once in 36 months.

Basic Plan

Covered services include:

- Fillings (amalgam or composite resin);
- Pin retention;
- Simple extractions of natural teeth and surgical extractions of fully erupted teeth;
- Root canal therapy (endodontics)
- Care for abscesses in the mouth (excision and drainage);
- Repair of broken removable dentures
- Surgical preparation of ridges for dentures;
- Re-cementing existing crowns, inlays and bridges (one every 12 months);
- Removing infected parts of the gum (gingivectomy and gingivoplasty);
- Scaling and root planning of the gum—two year limitation;
- Stainless steel crowns for primary teeth only;
- Sedative fillings;
- Therapeutic pulpotomy;
- Periodontal evaluation (not in addition to periodic evaluations);
- An operation to remove diseased portions of bone around the teeth (osseous surgery);
- Soft tissue grafts to replace lost or unhealthy gum tissue;
- Bone graft (only around natural teeth);

- Guided tissue regeneration;
- General anesthesia or IV sedation is covered when performed in connection with a covered, complex surgical dental service;
- Crown lengthening when bone is removed and at least six weeks are allowed for healing;
- Hemisection and root amputations;
- Apicoectomies;
- Surgical periodontic services (soft tissue and bony surgery, including grafts)—three year limitation;
- Full mouth debridement (once per lifetime);
- Core build ups (once per tooth every 5 years);
- Restorative (amalgam or composite resin and other restorative services) retreatment limited to once per surface in a 2 year period;
- Periodontal maintenance (limited to two (2) per Calendar Year); and
- Trips by the dentist to your home if you need any of the services you see listed here.

Major Dental Care

Covered services includes:

- Inlays (limited to the benefit for a resin restoration unless part of partial or bridge abutment);
- Onlays (limited to the benefit for a metallic restoration);
- Crowns, crown repair, and post and core build-ups for crowns (once per tooth every five years);
- Labial veneers involving the incisal edge of anterior teeth, porcelain laminate (laboratory processed);
- Dental implants (once every five (5) years);
- Dentures (full or partial) once every five (5) years, and denture adjustments and relining;
- Fixed bridges once every five (5) years, and repair.

Note: Replacement of prosthetic appliances, dentures, crowns, crown buildups, post and core to support crowns, onlays and bridges are limited to once every five-year period. There is one exception: replacement of a bridge will be provided prior to the end of the five-year period if one or more abutment teeth are extracted.

Enhanced Dental Benefits for Select Participants

There is a growing connection between oral health and overall body health. With the Anthem Whole Health Connection℠ program, participants who have been diagnosed with certain types of high-risk cardiac conditions, diabetes, those who are organ transplant candidates, those who have a cancer diagnosis and are undergoing chemotherapy and/or radiation therapy, or those who are pregnant are eligible for one additional cleaning or periodontal maintenance procedure and one additional examination beyond Your plan's ordinary limit per calendar year. In addition to an extra cleaning and exam, Anthem Whole Health Connection℠ provides cancer patients undergoing radiation or chemotherapy with an additional fluoride application beyond the age limitation of the group contract.

For more information, visit **www.anthem.com/cova** or call Anthem Dental Customer Service.

Conditions for Reimbursement

Should you decide to receive dental care from a dentist who is not a Participating Provider, You will still receive benefits from your dental plan, but your share of the cost will likely be higher than if you received care from a Participating Provider. In addition:

- You may have to file any claims yourself.
- Payment will be made directly to you unless your dentist agrees to accept payment from Anthem BlueCross BlueShield.
- You must pay the applicable Coinsurance plus any costs charged by the Non- Participating Provider that are above Anthem's payment for covered benefits.

Special Limits

1) Benefits are limited to $2,000 per participant per Calendar Year for all services.

2) If you transfer from the care of one dentist to another during a course of treatment, the Claims Administrator will only pay the amount it would pay to one dentist for the same treatment.

3) If more than one dentist renders services for one procedure, the Claims Administrator will only pay the amount it would pay to one dentist for the same treatment.

NOTE: If dental services for a single procedure or series of procedures cost more than $250, it is recommended that your dentist submit a predetermination plan to Anthem before services are provided. By submitting a predetermination plan, you and your dentist will be informed of:

- the total costs associated with the procedure(s);
- the exact amounts that will be covered by your health Plan; and
- the portion of the charges for which you will be responsible.

A predetermination plan is not required by your health Plan, but it is recommended when extensive dental work is expected. A claim will not be denied just for failure to obtain a predetermination plan.

Dental Plan Exclusions

The following services and/or supplies are excluded from coverage:

- Dental supplies;
- Brush biopsies of the oral cavity;
- Services rendered after the date of termination of the covered person's coverage. There is one exception. Covered prosthetic services which are prepped or ordered before the termination date are covered if completed within 30 days following the termination date;
- Gold foil restorations;
- Athletic mouth guards;
- Temporary dentures, crowns or duplicate dentures;
- Oral or inhalation sedation;
- Bleaching of discolored teeth;
- Dental pit/fissure sealants on other than first and second permanent molars;
- Root canal therapy on other than permanent teeth;

- Pulp capping (direct or indirect);
- Upgrading of working dental appliances;
- Precision attachments for dental appliances;
- Tissue conditioning;
- Separate charges for infection control procedures and procedures to comply with Occupational Safety and Health Administration (OSHA) requirements;
- Separate charges for routine irrigation or re-evaluation following periodontal therapy;
- Analgesics (nitrous oxide);
- General anesthesia and IV sedation except in conjunction with oral surgery, surgical periodontia, or surgical endodontia and then only when the underlying dental service is a covered benefit;
- Diagnostic photographs;
- Periodontal splinting and occlusal adjustments for periodontal purposes;
- Occlusal analysis;
- Controlled release of medicine to tooth crevicular tissues for periodontal purposes;
- Tooth desensitizing treatments;
- Care by more than one dentist when You transfer from one dentist to another during the course of treatment;
- Care by more than one dentist for one dental procedure, or by someone other than a dentist or qualified dental hygienist working under the supervision of a dentist;
- Preventive control programs, or oral hygiene instructions;
- Complimentary services or dental services for which the participant would not be obligated to pay in the absence of the coverage under Your health Plan or any similar coverage;
- Dental services for lost, misplaced or stolen prosthetic devices including orthodontic retainers, space maintainers, bridges and dentures (among other devices);
- Services that Anthem determines are for the purpose of cosmetic surgery or dentistry for cosmetic purposes;
- Services that Anthem determines are for the purpose of correcting congenital malformations or replacing congenitally missing teeth;
- Dental services for increasing vertical dimension, restoring occlusion, correcting developmental malformations, or for aesthetic purposes;
- Services billed under multiple dental service procedure codes which Anthem, in its sole discretion, determines should have been billed under a single, more comprehensive dental service procedure code. Anthem's payment is based on the allowance for the more comprehensive code, not on the allowances for the underlying component codes;
- Services covered under medical benefits;
- Any services not listed as covered under Dental Services in this summary plan description;
- Services determined by Anthem, in its sole discretion, to be not necessary or customary for the diagnosis or treatment of the condition. Anthem will take into account generally accepted dental practice standards in the area in which the dental service is provided. In addition, a covered person must have a valid need for each covered benefit. A valid need is determined in accordance with generally accepted standards of dentistry.

Reimbursement

The Claims Administrator pays the remaining Allowable Charge after Your Coinsurance for covered dental services.

You are responsible for any amounts above the Allowable Charge when using a Non-Participating Provider.

Coinsurance (the amount You pay)

Diagnostic and Preventive Care	0% of Allowable Charge
Basic Dental Care	20% of Allowable Charge
Major Dental Care	95% of Allowable Charge

VISION BENEFITS

Services Which Are Eligible for Reimbursement

1) Routine vision examination, once per Calendar Year

2) Frames and the following prescription lenses to correct refraction error, once per Calendar Year:

- Standard plastic single vision lenses, or
- Standard plastic bifocal lenses, or
- Standard plastic trifocal lenses, or
- Standard progressive lenses, or
- Conventional contact lenses

Conditions for Reimbursement

Vision services must be:

- Billed by a Provider in private practice.
- Rendered by a Provider licensed to do so
- Received from a Blue View Vision network Provider in order to receive in-network benefits
- Services received out-of-network will be reimbursed according to the out-of-network allowance.

Special Limits

1) These benefits are available once per Calendar Year.

2) Benefits will not be provided for more than the following in a Calendar Year period:

- One routine vision examination, and
- One pair of frames, and
- One pair of non-contact lenses or the designated allowance toward the cost of a supply of contact lenses.

Vision Plan Exclusions

Your coverage does not include benefits for the following routine vision services. This list includes the majority of vision services not covered under Your Plan, but is not a comprehensive list of all non-covered services. Contact your claims administrator to confirm any coverage not specifically listed in this Summary Plan Description.

1) Eye Surgery. Any medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism, or contact lenses and eyeglasses required as a result of this surgery.

2) Benefits cannot be combined with any offer, coupon, or in-store advertisement.

3) Prescription sunglasses of any type; however, discounts are available for nonprescription sunglasses, tints or transition lenses.

4) Discounts are not available for certain brand-name frames in which the manufacturer imposes a no-discount policy.

5) Services required by your employer in connection with employment or benefits that would be covered under worker's compensation.

6) Safety glasses and accompanying frames.

7) Hospital Care - Inpatient or Outpatient hospital vision care.

8) Orthoptics or vision training and any associated supplemental testing.

9) Any non-prescription lenses, eyeglasses, contacts, Plano lenses or lenses that have no refractive power.

10) Any other vision services not specifically listed as covered in this summary plan description.

Benefit/Reimbursement – In-Network

Covered Service – In-Network:	**Your cost:**
Routine vision examination	$20 Copayment
Eyeglass frames	**Plan pays** $100 allowance; you pay the
remaining	balance with a 20% discount
Eyeglass lenses *(one of the following)*	
Standard plastic single vision lenses (1 pair)	$20 Copayment
Standard plastic bifocal lenses (1 pair)	$20 Copayment
Standard plastic trifocal lenses (1 pair)	$20 Copayment
Standard progressive lenses (1 pair)	$85 Copayment

Upgrade eyeglass lenses

In addition to the standard eyeglass lens Copayment, you may choose to add one or more of the upgrades below for the additional Copayment(s).

• UV Coating	$15
• Tinted lenses *(solid and gradient)*	$15
• Standard scratch-resistance	$15
• Standard polycarbonate	$40
• Standard anti-reflective coating	$45
• Other add-ons and services	You pay the cost with a 20% discount

Contact lenses

You may choose to receive contact lenses instead of eyeglasses (frames and lenses).

• Elective conventional lenses	Plan pays $100 allowance; you pay the remaining balance with a 15% discount
• Elective disposable lenses	Plan pays $100 allowance; you pay the remaining cost
• Non-elective contact lenses	Plan pays $250 allowance; you pay the remaining cost

Elective contact lenses are in lieu of eyeglasses (frames and lenses). Non-elective lenses are covered when glasses are not an option for vision correction.

Contact lens fitting and follow-up

A contact lens fitting and up to two follow-up Visits are available to you once a comprehensive eye exam has been completed. The initial contact lens fitting must be performed during your comprehensive eye exam for the service to be covered.

Standard contact fitting — You pay up to $55
A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include, but are not limited to, disposable and frequent replacement lenses.

Premium contact lens fitting — You pay the cost with a 10% discount
A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include, but are not limited to, toric and multifocal lenses.

Additional savings on eyewear and accessories

After you use your initial frame or contact lens benefit allowance, you can take advantage of discounts on additional prescription eyeglasses, conventional contact lenses, and eyewear accessories at Blue View Vision network Providers at any time. The once per Plan Year

restriction does not apply. Blue View Vision's Additional Savings Program is subject to change without notice.

• Additional complete pair of eyeglasses (as many as you like)	40% off retail
• Conventional contact lenses (materials only)	15% off retail
• Additional eyewear & accessories (Includes eyeglass frames and eyeglass lenses purchased separately, some non-prescription sunglasses, eyeglass cases, lens cleaning supplies, contact lens solutions, etc.)	20% off retail

How to find a Blue View Vision Provider

Before you seek routine vision services, be sure to locate a Blue View Vision Provider. Go to Find a Doctor at **www.anthem.com/cova** or call Anthem Member Services at **800-552-2682** for help.

Always tell your routine vision Provider if you have Anthem's Blue View Vision. Network Providers can check your eligibility and automatically file your claims. When you receive care from a Blue View Vision participating Provider, you receive the greatest benefits and money-savings discounts.

Out-of-Network routine vision services

You can choose to receive care outside of the Blue View Vision network. The following allowances apply.

• Routine eye exam	$40 allowance
• Eyeglass frames	$75 allowance
• Standard plastic single vision lenses (1 pair)	$50 allowance
• Standard plastic bifocal lenses (1 pair)	$75 allowance
• Standard plastic trifocal lenses (1 pair)	$100 allowance
• Elective conventional and disposable lenses	$80 allowance
• Non-elective contact lenses	$210 allowance
• Standard Progressive Lenses	Not Covered

You must pay in full at the time of service and then submit a claim and itemized receipt for Reimbursement. Go to **www.anthem.com/cova** for an Out-of-Network claim form. Out-of-Network claims under Blue View Vision must be submitted within one year from the original date of service.

GENERAL EXCLUSIONS

This Plan does not provide benefits for services or supplies that are:

1) Not listed or described in this summary plan description as covered services.

2) Received by you before your Plan Effective Date.

3) For or rendered during an Inpatient admission which began prior to your Plan Effective Date.

4) Payable under Medicare (not including copayments or coinsurance that is secondary to Medicare-approved services or supplies).

5) Not Original Medicare Eligible Expenses, except as specifically covered by this Plan.

6) Not reasonable and necessary under Medicare program standards for diagnosing or treating a sickness or injury or for restoring a bodily function, except for services covered specifically covered by this plan.

7) Not usually accompanied with a charge. Also excluded are services for which you would not have been charged if you did not have health care coverage. Charges for self-administered services, self-care, self-help training, biofeedback, and related diagnostic testing are not covered.

8) Furnished by a federal Provider or other federal agency.

9) Provided or available to you:

- **a.** under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits Plans offered to either civilian employees or retired civilian employees of the federal or a state government. These latter Plans are subject to the rules explained in the General Rules Governing Benefits section.
- **b.** under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the secondary payer after benefits under this summary plan description have been provided. This exclusion applies whether or not you waive your rights under these laws, amendments, programs, or terms of employment.

10) For injuries or diseases related in any way to your job when:

- **a.** You receive payment from your employer on account of the disease or injury;
- **b.** Your employer is required by federal, state, or local laws or regulations to provide benefits to you, or;
- **c.** You could have received benefits for the injury or disease if you had complied with the laws and regulations.

This exclusion applies whether or not you have waived your rights to payment for the services available. It also applies if your employer (or your employer's health benefits

Claims Administrator) reaches any settlement with you for an injury or disease related in any way to your job.

11) For diseases contracted or injuries sustained as a result of any act of war (declared or undeclared), voluntary participation in civil disobedience, or other such activities.

12) Personal comfort items.

13) For rest cures, convalescent care, residential care, custodial care, care in a group home, halfway house, or residential setting.

14) For, or related to, cosmetic surgery, including routine complications thereof.

15) Determined to be not Medically Necessary by the Claims Administrator, in its sole discretion, for the treatment of an illness, injury, or pregnancy-related condition (for services specifically covered by these Plans but not covered by Medicare).

16) Determined to be Experimental/Investigative by the Claims Administrator, in its sole discretion. Also excluded are services to treat routine complications of any Experimental/Investigative service (for services specifically covered by these Plans but not covered by Medicare).

17) For routine foot care, the treatment of subluxation of the foot, the treatment of flat foot conditions, or orthopedic shoes and other supportive devices for the feet unless for treatment of injury or disease of the foot as approved for coverage by Medicare.

18) Provided by a member of your immediate family and services rendered by a Provider or Provider's Employee to a co-worker.

19) For radial keratotomy and other surgical procedures to correct nearsightedness and/or farsightedness. This type of surgery includes keratoplasty and Lasik procedure.

20) For audio-only telephone consultations, charges for failure to keep a scheduled visit, charges for completion of a claim form, or charges for giving information concerning a claim.

21) For abortions, except in the following cases, and only if not otherwise contrary to law:

- **a.** when Medically Necessary to save the life of the mother;
- **b.** when the pregnancy occurs as a result of rape or incest which has been reported to a law-enforcement or public health agency; and
- **c.** when the fetus is believed to have an incapacitating physical deformity or an incapacitating mental deficiency, which is certified by a Physician.

22) Dental treatment except as specifically covered under this plan, including Out-of-Country Major Medical Services. This exclusion also applies to dental treatment required as a result of a medical condition or treatment for a medical condition unless approved by Medicare. However, hospitalization required because of a medical condition which might become life-threatening if you were not hospitalized for the dental procedure is covered under the Major Medical Hospital Services provisions of the Out-of-Country provisions.

23) Services for vision training and vision therapy are excluded from coverage except as described in the Out-of-Country Major Medical provisions

24) Received through a Medicare Advantage Plan (HMO, PPO, Special Needs, Private Fee-for-Service). Claims paid in error for services covered through Medicare Advantage will be reversed.

BASIC PLAN PROVISIONS

(These provisions do not address Medicare as the primary payer on Medicare-covered services.)

1) The Department's Right to Change and Interpret Benefits

This Plan is sponsored by the Commonwealth of Virginia and administered by the Department of Human Resource Management. The Department is authorized to, and reserves the right to change this Plan to comply with the Line of Duty Act. The Department is also authorized and empowered to exercise discretion in interpreting the terms of the Plan and such discretionary determination will be binding on all parties.

2) You and Your Provider

You have the right to select your own Provider of care. Services provided by an institutional Provider are subject to the rules and regulations of the Plan you select. These include rules about admission, discharge, and availability of services. Neither the Claims Administrator nor the State guarantees admission or the availability of any specific type of room or kind of service. Neither the Claims Administrator nor the State will be responsible for acts or omissions of any facility. Neither the Claims Administrator nor the State will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a facility. Neither the Claims Administrator nor the State will be liable for breach of contract because of anything done, or not done, by a facility.

Similarly, the Claims Administrator is obligated only to pay, in part, for the services of your professional Provider to the extent the services are covered. Neither the Claims Administrator nor the State guarantees the availability of a Provider's services. Neither the Claims Administrator nor the State will be responsible for acts or omissions of any Provider. Neither the Claims Administrator nor the State will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a Provider. Neither the Claims Administrator nor the State will be liable for breach of contract because of anything done, or not done, by a Provider. The same limitations apply to services rendered or not rendered by a Provider's Employee.

You must tell the Provider that you are eligible for services. When you receive services, show your health Plan identification card. Show only your current card.

3) Privacy Protection and Your Authorization

Information may be collected from other people and facilities. This is done in order to administer your coverage. The information often comes from medical care facilities and medical professionals who submit claims for you. Collected information is generally disclosed to others only in accordance with the guidelines set forth in the Health Insurance Portability and Accountability Act (HIPAA) and in the Virginia Insurance Information and Privacy Protection Act. A more detailed explanation of the Claims Administrator's information practices is available upon request.

When you enroll in coverage under the Plan, You agree that the Claims Administrator may request any medical information or other records from any source when related to claims submitted to the Claims Administrator for services you receive.

By accepting coverage under the Plan, you authorize any individual, association, or firm which has diagnosed or treated your condition to furnish the Claims Administrator with necessary information, records, or copies of records. This authorization extends to any

person or organization which has any information or records related to the service received or to the diagnosis and treatment of your condition.

If the Claims Administrator asks for information and does not receive it, payment cannot be made. The claim will be processed only when the requested information or record has been received and reviewed.

Medical information is often highly confidential. You are entitled to review or receive only copies of medical information which applies to you. But, subject to the above, an Enrollee may review copies of medical records which pertain to enrolled dependent children under age 18.

4) The Personal Nature of These Benefits

Plan benefits are personal; that is, they are available only to you and your covered dependents. You may not assign (give to another person) your right to receive services or payment, except as provided in law. Prior payments to anyone will not constitute a waiver of or in any way restrict the Claims Administrator's right to direct future payments to you or any other individual or facility, even if there has been an assignment of payment in the past. This paragraph will not apply to assignments made to dentists and oral surgeons.

You and the Claims Administrator agree that other individuals, organizations, and health care practitioners will not be beneficiaries of the payments provided under this contract. This explanation of services and payments available to you is not intended for anyone else's benefit. As such, no one else (except for your personal representative in case of your death or mental incapacity) may assert any rights described in this summary plan description or provided under the Plan.

5) Proof of Loss

In many cases, the facility or Provider will submit your claim to the Claims Administrator. However, the Claims Administrator cannot process claims for you unless there is satisfactory proof that the services you received are covered. In most cases, "satisfactory proof" is a fully itemized bill which gives your name, date of the service, cost of the service, and the diagnosis for the condition. In some cases, the Claims Administrator will need additional proof, such as medical information or explanations. Your cooperation may be requested. Your claim cannot be processed until the needed information is received. All claims information and explanations submitted to the Claims Administrator must be in writing.

6) Prompt Filing of Claims

Payment of claims secondary to Medicare will be based on timely filing requirements per the provisions of the Patient Protection and Affordable Care Act (PPACA) which requires claims to be filed with the Medicare contractor no later than one Calendar Year (12 months) from the date of service. Claims for services that would be covered by Original Medicare but which are denied due to late filing are excluded from coverage under this Plan. Claims that are not covered by Original Medicare but are specifically covered under this Plan will be paid if the Claims Administrator receives it no later than 12 months after the end of the Calendar Year in which the services were received.

7) Payment Errors

Every effort is made to process claims promptly and correctly. If payments are made to you, or on your behalf, and the Claims Administrator finds at a later date the payments were incorrect, the Claims Administrator will pay any underpayment. Likewise, you must repay any overpayment. A written notice will be sent to the Enrollee if repayment is required.

8) Benefits Administrator and Other Plan Information

Your Benefits Administrator (see "Who to Contact for Assistance" section) is the appropriate person to assist you with your health care benefits. Your Benefits Administrator may also provide you information about your benefits. If there is a conflict between what Your Benefits Administrator tells you and the Plan, Your benefits will, to the extent permitted by law, be determined on the basis of the language in this summary plan description. The Benefits Administrator is never the agent of the Claims Administrator.

The Claims Administrator may send notices intended for you to your Benefits Administrator. You may be provided with another summary plan description, brochure, or other material which describes the benefits available under the Plan. In the event of conflict between this type of information and the Plan, Your benefits will be determined on the basis of the language in this summary plan description.

9) Continuation of Coverage – Extended Coverage

The right to Extended Coverage was created for private employers by federal law through COBRA, and these rights are reflected in the continuation coverage provisions of the Public Health Service Act which covers employees of state and local governments. Extended Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under the law, you should contact your designated Benefits Administrator. The "Who to Contact for Assistance" section of this summary plan description identifies your Benefits Administrator.

What is Extended Coverage?

Extended Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, Extended Coverage must be offered to each person who is a "qualified beneficiary." In general, as a LODA Plan – Medicare Primary participant (covered based on former employment), your covered family members could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. These rights are also available to children covered through a Qualified Medical Child Support Order (QMCSO). Under the Plan, qualified beneficiaries who elect Extended Coverage must pay the full cost for Extended Coverage. Time limitations for making Extended Coverage premium payments will be included in the Election Notice provided at the time of the qualifying event.

If one of the qualifying events listed below resulted in Your loss of active employee coverage in the LODA Plan – Current Employment and Your resulting coverage in this plan ends prior to the expiration of Your initial 18-month Extended Coverage eligibility period, You may

utilize any remaining months of that eligibility if You enroll within 60 days of the loss of this coverage due to the following events:

- Your hours of employment were reduced (e.g., long-term disability).
- Your employment ended for any reason other than your gross misconduct.

If you are a LODA Eligible Spouse, You will become a qualified beneficiary if you lose your coverage under the Plan because you become divorced from the spouse through whom your eligibility is attained.

If you are a LODA Eligible Dependent Child (as defined by the Line of Duty Act), you will become a qualified beneficiary if you lose coverage under the Plan because you stop being eligible for coverage under the plan (for example, you reach the limiting age).

Coverage that is terminated in anticipation of a qualifying event (e.g., divorce) is disregarded when determining whether the event results in a loss of coverage. If termination occurs under this condition but notification of the qualifying event is received from the LODA Disabled Person, qualified beneficiary or a representative within 60 days of the date coverage would have been lost due to the qualifying event, Extended Coverage must be made available and effective on the date coverage would have been lost due to the event, but not before.

You Must Give Notice of Qualifying Events

When the qualifying event is divorce or a dependent child's loss of eligibility for coverage as a dependent child, You or Your representative must notify Your Benefits Administrator within 60 days of the date coverage would be lost due to the qualifying event by submitting written notification to include the following information:

- The type of qualifying event (e.g., divorce, loss of dependent child's eligibility--including reason for the loss of eligibility);
- The name of the affected qualified beneficiary (e.g., spouse's and/or dependent child's name/s);
- The date of the qualifying event;
- Documentation to support the occurrence of the qualifying event (e.g., final divorce decree);
- The written signature of the notifying party;
- If the address of record is incorrect, an address for mailing the Election Notice.

Failure to provide timely notice of these qualifying events will result in loss of eligibility for continuation coverage. One notice will cover all affected qualified beneficiaries. Notice will be considered furnished when mailed or, in the case of hand delivery, the date it is received by Your Benefits Administrator.

How is Extended Coverage Provided?

Once the designated LODA Health Benefits Plans Benefits Administrator becomes aware of or is notified that the qualifying event has occurred, Extended Coverage will be offered to each of the qualified beneficiaries. (One notice will cover all qualified beneficiaries living at the same address.) Each qualified beneficiary will have an independent right to elect Extended Coverage. Covered LODA Plan Enrollees may elect Extended Coverage on

behalf of an eligible spouse, and parents may elect Extended Coverage on behalf of their eligible children.

Extended Coverage is a temporary continuation of coverage. When the qualifying event is divorce, or a dependent child's loss of eligibility as a dependent child, Extended Coverage lasts for up to a total of 36 months.

If you have questions:

Questions regarding Extended Coverage should be directed to your LODA Benefits Administrator at DHRM.

10) Claims Administrator's Continuing Rights

On occasion, the Claims Administrator or DHRM may not insist on your strict performance of all terms of this Plan. Failure to apply terms or conditions does not mean the Claims Administrator or DHRM waives or gives up any future rights it may have. The Claims Administrator or DHRM may later require strict performance of these terms or conditions.

11) Time Limits on Legal Actions and Limitation on Damages

No action at law or suit in equity may be brought against the Claims Administrator, DHRM or the State in any matter relating to (1) the Plan, (2) the Claims Administrator's performance or DHRM's performance under the Plan; or (3) any statements made by an employee/retiree, officer, or director of the Claims Administrator, DHRM or the State concerning the Plan or the benefits available if the matter in dispute occurred more than one year ago.

In the event you or your representative sues the Claims Administrator, DHRM, or the State or any director, officer, or employee of the Claims Administrator, DHRM, or the State acting in a capacity as a director, officer, or employee, your damages will be limited to the amount of your claim for covered services. The damages will not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. In no event will this contract be interpreted so that punitive or indirect damages, legal fees, or damages for emotion distress or mental anguish are available.

12) Services After Amendment of This Plan

A change in this Plan will change covered services available to you on the Effective Date of the change. This means that your coverage will change even though you are receiving covered services for an ongoing illness, injury, pregnancy-related condition, or if you may need more services or supplies in the future.

An exception applies if you are an Inpatient on the day a change becomes effective. Covered services Your Hospital provides you under this plan (not including Medicare-covered services) will not be changed for that admission**.**

13) Misrepresentation

A Disabled Person's or covered spouse's or dependent's coverage can be canceled by the Claims Administrator, DHRM, or the State if it finds that any information needed to accept the Disabled Person, covered spouse or covered dependent or process a claim was deliberately misrepresented by, or with the knowledge of, the Disabled Person, covered spouse or covered dependent. When false or misleading information is discovered, the Claims Administrator, DHRM, or the State may cancel coverage retroactive to the date of misrepresentation.

14) Divorce

Coverage will end for the enrolled spouse of a Disabled Person on the last day of the month in which the final divorce decree is granted unless continuation of coverage is properly elected and maintained pursuant to Extended Coverage/COBRA provisions. Conversion privileges for the spouse will be extended if the spouse notifies the Claims Administrator of the divorce in writing within 31 days after the end of the month in which the divorce is granted or within 31 days of the end of Extended Coverage. Failure to terminate coverage of an ineligible dependent can result in retroactive termination and retraction of all claims paid in error, including prescription drugs.

15) End of Coverage for an Eligible Spouse or Eligible Dependent

When a spouse or child is no longer eligible for coverage, the Benefits Administrator must be notified, and coverage will terminate at the end of the month in which the loss of eligibility occurs. Continuation coverage may be elected pursuant to Extended Coverage/COBRA provisions. Conversion privileges will be offered if the Claims Administrator receives notice within 31 days after the end of the month in which the loss of eligibility event occurs or within 31 days of the end of Extended Coverage. Failure to terminate coverage of an ineligible dependent can result in the Enrollee's suspension from the program retroactive termination and retraction of all claims paid in error, including prescription drugs.

16) Disclosure of Protected Health Information (PHI) to the Employer, or Former Employer

(1) Definitions. Whenever used in this Article, the following terms shall have the respective meanings set forth below.

(a) Plan - means the "LODA Health Benefits Plans."
(b) Employer - means your LODA employer or former LODA employer."
(c) Plan Administration Functions - means administrative functions performed by DHRM on behalf of the Plan.
(d) Health Information - means information (whether oral or recorded in any form or medium) that is created or received by a health care Provider, health plan (as defined by the Health Insurance Portability and Accountability Act of 1996, subsequently referred to as HIPAA, in 45 CFR Section 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined by HIPAA in 45 CFR Section 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.
(e) Individually Identifiable Health Information - means Health Information, including demographic information, collected from an individual and created or received by a health care Provider, health plan, employer, or health care clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.
(f) Summary Health Information - means information that summarizes the claims history, expenses, or types of claims by individuals for whom DHRM provides benefits under the Plan, and from which the following information has been removed: (1) names; (2) geographic information more specific than state; (3) all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and

elements may be aggregated into a single category of age 90 and older); (4) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers; (5) facial photographs or biometric identifiers (e.g., finger prints); and (6) any information DHRM does not have knowledge of that could be used alone or in combination with other information to identify an individual.

(g) Protected Health Information ("PHI") means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

(2) The Plan, and the agents acting on its behalf, may disclose Summary Health Information to DHRM if DHRM requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

(3) The Plan, and the agents acting on its behalf, will disclose PHI to DHRM only in accordance with HIPAA in 45 CFR Section 164.504(f) and the provisions of this Section.

(4) The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose PHI to DHRM and acknowledges receipt of written certification from DHRM that the Plan has been so amended. Additionally, DHRM agrees:

(a) not to use or further disclose PHI other than as permitted in Section (4) or as required by law;
(b) to ensure that any of its agents or contractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;
(c) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;
(d) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in Section (4);
(e) to make PHI available to individuals in accordance with HIPAA in 45 CFR Section 164.524;
(f) to make PHI available for individuals' amendment and incorporate any amendments in accordance with HIPAA in 45 CFR Section 164.526;
(g) to make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA in 45 CFR Section 164.528;
(h) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan and its agents available to the Department of Health and Human Services upon request; and
(i) if feasible, to return or destroy all PHI received from the Plan that DHRM maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, DHRM will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible.
(j) to ensure that adequate separation between the Plan and DHRM, as required by HIPAA in 45 CFR Section 164.504(f), is established and maintained.

(5) The Plan will disclose PHI only to the following employees or classes of employees:

- Director, Department of Human Resource Management (DHRM)
- Director of Finance, Department of Human Resource Management (DHRM)
- Staff Members, Office of Health Benefits

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that DHRM performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

(6) Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Section by individuals described in Section (5) shall be considered "failure to comply with established written policy" (a Group II offense) and must be addressed under the Commonwealth of Virginia's Policy 1.60, Standards of Conduct Policy. The appropriate level of disciplinary action will be determined on a case-by-case basis by the agency head or designee, with sanctions up to or including termination depending on the severity of the offense, consistent with Policy 1.60.

(7) A health insurance issuer, HMO or third party administrator providing services to the Plan is not permitted to disclose PHI except as would be permitted by the Plan in this Article and only if a notice is maintained and provided as required by HIPAA in 45 CFR Section 164.520.

DEFINITIONS

Throughout this summary plan description are words which begin with capital letters. In most cases, these are defined terms. This section gives you the meaning of most of these words. Since Medicare is primary under this Plan (except where a non-Medicare-covered service is specifically covered), Medicare's definition of terms would apply to Medicare-covered services.

1) Allowable Charge
For care by a Physician or other health care professional which is not covered by Medicare, the Allowable Charge is the lesser of the Claims Administrator's allowance for that service, or the Provider's charge for that service.

For Hospital services not covered by Medicare, the Allowable Charge is the Claims Administrator's negotiated compensation to the facility for the covered service, or the facility's charge for that service, whichever is less.

For other services that are not covered by Medicare which are not considered Provider or facility services, the Allowable Charge is the amount the Claims Administrator determines to be reasonable for the services rendered. Medicare's Allowable Charge is Medicare's allowance for a covered service.

2) Annual Notice of Changes
An annual summary of any changes to your benefits and costs for the upcoming plan year provided by your Prescription Drug Plan (PDP) Administrator.

3) At-Home Recovery Visit
This means the period of a visit required to provide At-Home Recovery Care, without limit on the duration of the visit except as provided in Special Limits.

4) Benefit Period
See Major Medical Benefit Period or Medicare Benefit Period.

5) Benefit Overview
An annual summary of your Medicare Part D plan benefits provided by your Prescription Drug Plan (PDP) Administrator.

6) Calendar Year
This is the period beginning January 1 and ending on the following December 31.This is also the Out-of-Country Major Medical Benefit Period.

7) Claims Administrator
The administrator who adjudicates and processes claims. The Claims Administrator is indicated in the front of this Summary Plan Description.

8) Covered Facility
This means an institution in which, or through which, you receive covered services. Covered Facilities under this Plan are:

- Hospitals
- Skilled Nursing Facilities

9) Days of Inpatient Care

This means the number of days of care for which you are covered as an Inpatient. Days of Inpatient Care You use in a Covered Facility are subtracted from those available in this way:

- the day you are admitted, if applicable, is subtracted.
- each day, up to the day of discharge, is subtracted.
- the day you are discharged is not subtracted.

You must be discharged by the established discharge hour. If you stay beyond the established discharge hour, the Claims Administrator will pay for Inpatient services only if your longer stay was Medically Necessary.

10) DHRM

This is the Department of Human Resource Management, Plan and Benefits Administrator for the LODA Health Benefits Plans.

11) Diagnostic Services

This means the following procedures when ordered by Your doctor to diagnose a definite condition or disease because of specific signs and/or symptoms, including:

- laboratory and pathology services or tests;
- diagnostic EKGs, EEGs;
- radiology (including mammograms), ultrasound or nuclear medicine; and
- sleep studies.

Diagnostic Services do not include routine or periodic physical examinations or screening examinations.

12) Disabled Person

This is the person who was injured in the line of duty and through whom eligibility for this plan is attained per the provisions of the Line of Duty Act.

13) Effective Date

This is the date coverage begins for you and/or your eligible family members enrolled under the health plan.

14) Emergency Services

These are Medically Necessary services provided to you in response to a sudden and acute illness or injury which, if left untreated, would result in death or severe physical or mental impairment.

15) Enrollee

This word means the person who applies for coverage in this Plan and through whom dependent coverage is obtained.

16) Experimental/Investigative

This means any service or supply that is judged to be experimental or investigative at the Claims Administrator's sole discretion. Services which do not meet each of the following criteria will be excluded from coverage as Experimental/Investigative:

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration (FDA) for the particular indication or application in question. Moreover, quantities of any drug or medication that could be covered under this medical coverage must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia as defined below. There are exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.

   a) This criterion will be satisfied if the use of the supply or drug is recognized for treatment of the indication or application in any of the following resources.

      The following standard reference compendia:

      1) the U.S. Pharmacopoeia dispensing Information;
      2) the American Medical Association Drug Evaluations; or
      3) the American Hospital Formulary Service Drug Information; or
      in substantially accepted peer reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or

   b) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

   Despite the above exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is contraindicated for the treatment of the specific indication for which it is prescribed.

2. There must be enough information in the peer-reviewed medical and scientific literature to let the Claims Administrator judge the safety and efficacy;
3. The available scientific evidence must show a good effect on health outcomes outside a research setting; and
4. The service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.

A service or supply will be experimental or investigative if the Claims Administrator determines that any one of the four criteria is not met.

17) Hospital

a. This word means an institution which meets the American Hospital Association's standards for registration as a Hospital. It must be mainly involved in providing acute care for sick and injured Inpatients. The institution must be licensed as a Hospital by the State in which it operates.

It must also have a staff of licensed Physicians and provide 24 hour nursing service by or under the supervision of Registered Nurses (R.N.s). Except in unusual cases approved in advance by the Claims Administrator, an institution will not be considered a Hospital if its average length of Stay is more than 30 days.

b. This word also means a facility providing Surgical Services to Outpatients. The facility must be licensed as an Outpatient Hospital by the state in which it operates. Inpatient services received from a facility of this type are not covered. Services provided by an Outpatient Hospital which is a Non-Network Hospital are not covered.

18) Inpatient

This term refers to a person who:

- is admitted to a Hospital or Skilled Nursing Facility;
- is confined to a bed there; and
- receives meals and other care in that facility.

19) Major Medical Benefit Period

This is a Calendar Year. It can also mean a part of a Calendar Year if Your Effective Date is other than January 1 or if your enrollment ends other than on December 31. Your first Major Medical Benefit Period extends from Your Effective Date to the next December 31. If your coverage is terminated for any reason, Your Major Medical Benefit Period will end on the same day your enrollment ends. Major medical services under this plan are limited to those received out of the country, as defined.

20) Medically Necessary

To be considered Medically Necessary, a service must:

- be required to identify or treat an illness, injury, or pregnancy-related condition;
- be consistent with the symptoms or diagnosis and treatment of your condition;
- be in accordance with standards of generally accepted medical practice; and
- be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the Provider.

Only your medical condition is considered in deciding which setting is Medically Necessary. Your financial or family situation, the distance you live from a Covered Facility, or any other non-medical factor is not considered. As your medical condition changes, the need for a particular setting may change.

21) Medically Skilled Service

This is a service requiring the training and skills of a licensed medical professional. A service is not medically skilled simply because it is performed by medical professionals. If someone else can safely and adequately perform the service without direct supervision of a nurse or Provider, it will be classified as a non-Medically Skilled Service and will not be eligible for reimbursement.

22) Medicare

Medicare means the program established by Title XVIII of the Social Security Act of 1965, as amended. Medicare covers people age 65 and older and some people under 65 who are disabled.

The Original Medicare plan has two parts. One part is called Hospital Insurance. This is Part A. Medical Insurance is Part B. Also, beginning January 1, 2006, Medicare Part D, the Medicare prescription drug benefit, became available to Medicare beneficiaries. See the Medicare handbook, published each year by the federal government, for more information about Medicare.

23) Medicare-Approved Charges

This is the maximum amount Medicare will pay for a Covered Provider Service. Medicare-Approved Charges will not always cover Your Provider's entire bill.

24) Medicare Benefit Period

This means a period of time Medicare uses to measure Hospital or Skilled Nursing Facility services. It starts when you are admitted to a Covered Facility and ends when you have not been an Inpatient in any Covered Facility for 60 days in a row.

25) Medicare Lifetime Reserve Days

These are the extra Medicare Part A Hospital days You have left after You have used all of Your regular Medicare Part A Hospital days.

26) Out-of-Pocket Expenses

This means any deductible or coinsurance you incur for covered out-of-country major medical services. There are limits as to expenses that apply to your out-of-country major medical expense limit.

27) Outpatient

This term refers to a person who is not an Inpatient. An Outpatient is a person who receives care in a professional Provider's office, Hospital Outpatient department, emergency room, or the home, for example.

28) Participant

This means the disabled person or eligible family members while enrolled in this Plan.

29) Participating and Non-Participating Hospitals

A Participating Hospital is a Hospital listed as "participating" by the Claims Administrator. The Hospital must be listed as such at the time you receive the service for which coverage is sought. Any other Hospital is a Non-Participating Hospital. The Claims Administrator may, at its sole option, name one or more Non-Participating Hospitals as ones in which you will receive covered services as if you were in a Participating Hospital.

30) Participating and Non-Participating Providers

A Participating Provider is a Provider who is listed as a "Participating Provider" by the Claims Administrator. The Provider must be listed as such at the time you receive the service for which coverage is sought. A Participating Provider will accept the Claims Administrator’s Allowable Charge for services not covered by Medicare. A Non-Participating Provider means any other Provider including a Provider who participates with another Blue Shield plan. A Non-Participating Provider has not agreed to accept the Claims Administrator’s Allowable Charge as payment in full for services rendered. This means that you are responsible for any difference between the Claims Administrator’s Allowable Charge and the Non-Participating Provider’s charge.

31) Physician

A Physician is a properly licensed Doctor of Medicine.

32) Plan

Plan, in this Summary Plan Description, means the **LODA Plan – Medicare Primary**.

33) Plan Administrator

This is the Department of Human Resource Management (DHRM)

34) Primary Coverage

This means the Health Benefit Plan which will provide benefits first. It does not matter whether or not you have filed a claim for benefits with the primary Health Benefit Plan. If you are eligible for coverage under two Health Benefit Plans, the Primary Coverage will be used to decide what Secondary Coverage benefits are available. Enrollment in this plan indicates Medicare is primary for all Medicare-covered services.

35) Provider

This means a properly licensed Audiologist, Certified Nurse Midwife, Chiropractor, Clinical Nurse, Clinical Social Worker, Dentist, Doctor of Chiropody, Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Licensed Professional Counselor, Mental Health Specialist, Optician, Optometrist, Psychologist, Registered Physical Therapist, or Speech Pathologist.

36) Provider's Employee

A Provider's Employee is an allied health professional who works for the Provider. The Provider must withhold federal and state income and social security taxes from the Provider's Employee's salary. A medical or surgical service which would have been covered if performed by Your Provider will be covered if performed by Your Provider's Employee, but only when:

- the Provider's Employee is licensed to perform the service;
- the service is performed under the direct supervision of Your Provider; and
- the services of the Provider's Employee are billed by Your Provider.

The services of the Provider's Employee are available as a substitute for the services of the Provider. For this reason, the Claims Administrator will not pay a supervisory or other fee for the same service rendered by both the Provider and the Provider's Employee.

37) Secondary Coverage

This is the Health Benefit Plan under which the benefits may be reduced to prevent duplicate or overlapping coverage. This includes the coverage provided as secondary payment to Medicare under this plan

38) Semi Private Room

This phrase means a room with two, three, or four beds, all of which are used for Inpatient care.

39) Skilled Nursing Facility

A Skilled Nursing Facility is an institution licensed as a Skilled Nursing Facility by the state in which it operates. A Skilled Nursing Facility provides Medically Skilled Services to Inpatients. In most cases, the Inpatients require a lesser level of care than would be provided in a Hospital.

40) State

This means the Commonwealth of Virginia.

41) Therapy Services

This phrase means one or more of the following services used to treat or promote your recovery from an illness or injury.

a. Chemotherapy

This is treatment of malignant disease by using chemical or biological antineoplastic agents.

b. Inhalation Therapy

This is treatment of impaired breathing. It may be done by introducing specialized gases into your lungs by mechanical means.

c. Occupational Therapy

This is treatment to restore your ability to perform the ordinary tasks of daily living. These tasks may include special skills required by the job you had at the time of your illness or injury.

d. Physical Therapy

This is treatment required to relieve pain, restore function, or prevent disability following illness, injury, or loss of limb.

e. Radiation Therapy

This is treatment using x-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

f. Respiratory Therapy

This is treatment using the introduction of dry or moist gases into the lungs to treat illness or injury.

g. Speech Therapy

This is treatment for the correction of a speech impairment. The impairment must result from disease, surgery, injury, congenital anatomical anomaly, or previous therapeutic process.

ELIGIBILITY AND ENROLLMENT

Who Is Eligible for Coverage?

As set forth in the Line of Duty Act, coverage in the LODA Health Benefits Plans is limited to:

- certain public employees or volunteers who are disabled in the line of duty (disabled persons) and their eligible spouses and eligible dependents; or,
- the eligible spouse and eligible dependents of certain public employees or volunteers who are killed in the line of duty (deceased persons).

For this specific plan (LODA Plan – Medicare Primary), participants are covered based on the **former LODA employment** of the disabled or deceased person, are **eligible for Medicare**, and maintain eligibility for LODA Health Benefits Plans coverage upon eligibility for Medicare. See the ***Grandfathered Participants*** section below for additional information.

Determination of eligibility for Line of Duty Act benefits is the sole responsibility of the Virginia Retirement System (VRS). The Department of Human Resource Management (DHRM) will determine eligibility for and administer the LODA Health Benefits Plans.

When does coverage begin?

The Effective Date of coverage shall be the first day of the month following determination of eligibility for Line of Duty Act benefits by the VRS if DHRM determines that the participant is eligible for this Medicare primary plan. Failure to enroll within 60 days of eligibility determination will result in loss of this benefit.

Disabled Person

The LODA-disabled person is eligible for this plan if he or she is no longer actively working for the LODA employer, is eligible for Medicare, and maintains eligibility for LODA Health Benefits Plans coverage upon eligibility for Medicare based on the provisions of the Line of Duty Act.

Eligible Spouse

This is the legal spouse of the deceased or disabled person at the time of the death or disability. The disabled person must be covered based on former (not current) LODA employment, and the spouse must maintain eligibility for LODA Health Benefits Plans coverage upon eligibility for Medicare based on the provisions of the Line of Duty Act.

Eligible Dependents

This the natural or adopted child or children of a deceased person or disabled person or of a deceased or disabled person's eligible spouse, provided that any such natural child is born as the result of a pregnancy that occurred prior to the time of the employee's death or disability and that any such adopted child is adopted prior to the time of the employee's death or disability. The disabled person must be covered based on former (not current) LODA employment, and the eligible dependent must maintain eligibility for LODA Health Benefits Plans coverage upon eligibility for Medicare prior to reaching the limiting age. This also includes children adopted after the date of death or disability pursuant to a pre-adoptive agreement entered into prior to the death or disability.

Eligible children born or adopted after the date of death or disability, but eligible based on the above criteria, must be reported to the Department of Human Resource Management within 60 days of the birth or adoption event, and coverage will be effective on the date of the birth or adoption event. Failure to report these events within the 60-day enrollment window will result in loss of the child's eligibility for the LODA health benefit.

Children Placed for Adoption

Children placed for adoption pursuant to a pre-adoptive agreement entered into prior to the date of LODA death or disability are eligible for this plan. Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation. An agreement for full or partial support of a child will constitute a legal obligation only if the obligation is enforceable in a court of competent jurisdiction, which depends on the facts and circumstances associated with the agreement. The disabled or deceased person must have been party to the agreement and the agreement must have extended beyond the obligation to provide Medical coverage.

When does Coverage in this Plan End?

Eligibility for the disabled person shall continue until the end of the month in which:

- the disabled person ceases to be disabled; or
- the disabled person becomes eligible for Medicare due to age (see "Grandfathered Participants"); or
- the disabled person returns to full duty; or
- the disabled person dies.

Eligible spouses' coverage continues until the end of the month in which:

- the disabled person ceases to be eligible (except when eligibility is lost due to Medicare eligibility due to age); or
- the spouse ceases to be married to the disabled person; or
- the spouse of a deceased person remarries (see "Grandfathered Participants"); or
- the spouse becomes eligible for Medicare due to age; or
- the spouse dies.

Eligible dependents' coverage continues until:

- the end of the month in which the disabled person ceases to be eligible (except when eligibility is lost due to Medicare eligibility due to age); or
- the end of the year in which the child turns age 26 (unless the child is determined to be permanently incapacitated—see "Incapacitated Dependents"); or
- the end of the month in which the incapacitated child ceases to be disabled or becomes eligible for Medicare due to age; or
- the eligible dependent dies.

Suspension Due to Income

Eligibility for participating disabled persons whose disability occurred on or after July 1, 2017, including their covered family members, shall be suspended effective the first of the Plan Year following a calendar year in which the disabled person through whom eligibility is attained has earned income in an amount equal to or greater than the salary of the position held by the disabled person at the time of disability, indexed annually based upon the annual increases in the United States Average Consumer Price Index for all items, all urban consumers (CPI-U), as published by the Bureau of Labor Statistics of the U. S. Department of Labor. Such suspension shall cease effective the Plan Year following a calendar year in which the disabled person has not earned such amount of income.

The disabled person shall notify the participating or non-participating employer, the Virginia Retirement System (VRS), and the Department of Human Resource Management (DHRM) no later than March 1 of the year following any year in which he earns income of such amount. Failure to report such income shall result in retroactive termination of coverage and retraction of claims paid in error back to the point at which coverage should have been terminated had the income been timely reported. This will include the repayment of any prescription drug claims paid in error which cannot be otherwise recovered.

It will also be the responsibility of the disabled person to notify the participating or non-participating employer, VRS, and DHRM no later than March 1 of the year following any year in which he ceases to earn such income. Suspension shall cease effective the Plan Year following a calendar year in which the disabled person has not earned such amount of income.

A disabled person shall provide VRS and DHRM with documentation of earned income when reporting the above events or upon request.

Grandfathered Participants

LODA-eligible disabled persons or family members whose eligibility is based on a date of disability or death that is prior to July 1, 2017, are grandfathered for certain LODA Health Benefits Plans benefits/provisions as follows:

- Surviving spouses who remarried prior to July 1, 2017, will not lose LODA Health Benefits Plans coverage due to the remarriage. (This does not include any subsequent remarriage.)
- Disabled persons whose date of disability is prior to July 1, 2017, will not be subject to suspension of their LODA Health Benefits Plans coverage due to income.
- Disabled persons, eligible spouses and eligible dependents whose eligibility for LODA Health Benefits Plans coverage is based on a date of disability or death that is prior to July 1, 2017, will not lose LODA Health Benefits Plans coverage upon eligibility for Medicare, regardless of reason.

Incapacitated Dependents

Otherwise eligible dependents, as defined, may continue coverage after the limiting age if they are determined to be incapacitated due to a physical or mental health condition that existed prior to termination due to reaching the limiting age. Written application must be made, including proof of incapacitation, prior to loss of coverage due to age. Such extension of coverage must be approved by the LODA Health Benefits Plan and is subject to periodic review. If the dependent no longer meets the criteria for coverage as an incapacitated child, the child's

coverage will be terminated at the end of the month that the child is determined to no longer be incapacitated. In addition, the dependent must live with the disabled person or with the custodial parent with whom he or she lived at the time eligibility was originally determined; be unmarried; and, be incapable of self-support as evidenced by inability to obtain employment or live outside of a parent's home. Cooperation with periodic review is required to maintain coverage. In any case, eligibility for LODA Health Benefits Plans coverage will be terminated at the time the incapacitated dependent attains Medicare-eligible age.

Who Is Not Eligible For Coverage

Eligibility is limited to individuals specifically defined as eligible under the provisions of the Line of Duty Act, specifically listed as eligible within this document, and not listed as ineligible within this document.

You cannot cover a person as a dependent unless that person is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico. However, if the child is otherwise eligible, there is an exception for certain adopted children. If you are a U.S. citizen or U.S. national who has legally adopted a child who is not a U.S. citizen, U.S. resident alien, or U.S. national, you may cover the child if the child lives with you as a member of your household. This exception also applies if the child was lawfully placed with you for legal adoption.

Participants who enroll or fail to remove ineligible persons will be responsible for all claims paid in error, including any claims paid for prescription drugs.

Terminations Required by the Plan

You can only provide coverage for family members who meet the Line of Duty Act Health Benefits Plans' eligibility criteria. In cases where there is a loss of eligibility, the Effective Date of the change is based on the date of the event.

After Coverage Ends

Benefits will not be paid for charges you incur after coverage ends. There are two exceptions. If you are an Inpatient the day your coverage ends, your Facility and Professional Provider coverage will continue until you are discharged to the extent that services were covered prior to the end of coverage (including applicable coordination of benefits). This would include all types of confinement: Acute Care Facility, rehabilitation and Skilled Nursing Facility. All services must continue to meet Medical necessity guidelines. Also, Other Covered Services such as rental of Medical Equipment (durable) will be provided for a limited time for a condition for which you received covered services before your coverage ended. The time will be the shorter of when you become covered under any other group coverage, or the end of the Plan Year your coverage ends, or a period equal to the time you were enrolled under Your Health Plan.

When You Become Eligible for Medicare

LODA Health Benefits Plans participants who become eligible for Medicare must report that eligibility to their Benefits Administrator immediately. **Non-grandfathered LODA Plan – Former LODA Employment participants (those covered based on a LODA death or disability that occurred on or after July 1, 2017) who are eligible for Medicare due to age are no longer eligible for any LODA Health Benefits Plan, including this plan**. (Otherwise-Medicare-eligible persons become eligible for Medicare due to age on the first day of the month

in which they reach age 65 or, if the date of birth is on the first of the month, the first of the month prior to reaching age 65.)

In addition to grandfathered participants, the Line of Duty Act provides an exception to the above loss-of-eligibility event. Any disabled person whose date of disability is on or after July 1, 2017, and who becomes continuously eligible for Medicare due to disability, as determined by the Social Security Administration or the Railroad Retirement Board Disability Annuity, up to the date that they reach the Medicare eligibility age may continue coverage in the LODA Plan – Medicare Primary until he ceases to be disabled, returns to full duty, or dies.

This means that:

- Grandfathered participants will not lose eligibility for LODA Health Benefits Plans coverage based on eligibility for Medicare, regardless of reason.
- Non-grandfathered disabled persons covered based on former employment may continue coverage in the LODA Health Benefits Plans if they become continuously eligible for Medicare due to disability up to the Medicare-eligibility age and may remain in the plan even after they attain the Medicare-eligibility age.
- Non-grandfathered disabled persons who become eligible for Medicare due only to age will lose eligibility for any LODA Health Benefits Plans.
- Non-grandfathered eligible spouses and eligible adult incapacitated dependents covered based on former employment may continue coverage in the LODA Health Benefits Plans upon eligibility for Medicare due to disability; however, they will lose all eligibility for LODA Health Benefits Plans coverage upon attaining the Medicare-eligible age.

Any LODA Health Benefits Plans participants covered based on former employment and who, based on the above policy, may continue coverage after Medicare eligibility must enroll in Medicare Parts A and B, which will become their primary coverage. Failure to enroll in Medicare Parts A and B immediately upon eligibility will result in a gap in coverage since the LODA Plan – Medicare Primary will not pay any claims that should have been paid by Medicare had required enrollment taken place. To enroll in Medicare, contact Social Security at **800-772-1213**, contact the nearest Social Security Office, or go to **www.ssa.gov.**

If the Disabled Person Dies:

Upon the death of the LODA-disabled person, eligible family members may continue coverage if they remain otherwise eligible per the provisions of the Line of Duty Act.

Continuing Coverage When Eligibility Ends:

Certain qualifying events will result in eligibility for Extended Coverage per the provisions of the Public Health Service Act. Additional information is provided in the General Notice of Extended Coverage Rights in the **Basic Plan Provisions Section, Continuation of Coverage, Extended Coverage**.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Background: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the LODA Health Benefits Plans administered by the Virginia Department of Human Resource Management, and the agents acting on its behalf, as the group health plans (the Plans).

The Plans need to create, receive, and maintain records that contain health information about you to administer the Plans and provide you with health care benefits. This notice describes the Plans' health information privacy policy with respect to Your Health Plan including Medical, Prescription Drug, Dental, Vision and Health Care Flexible Reimbursement Account (FRA) benefits. The notice tells you the ways the Plans may use and disclose health information about you, describes your rights, and the obligations the Plans have regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care Providers.

The Department of Human Resource Management's Pledge Regarding Health Information Privacy

The privacy policy and practices of the Plans protects confidential health information that identifies you or could be used to identify you and relates to a past, present, or future physical or mental health condition or the past, present or future payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Privacy Obligations of the Plans

The Plans are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of the Plans' legal duties and privacy practices with respect to health information about you;
- notify you if you are affected by a breach of unsecured PHI; and
- follow the terms of the notice that is currently in effect.

How the Plans May Use and Disclose Health Information About You

The following are the different ways the Plans may use and disclose your PHI:

For Treatment. The Plans may disclose your PHI to a health care Provider who renders treatment on your behalf. For example, if you are unable to provide your Medical history as the result of an accident, the Plans may advise an Emergency room physician about the types of prescription drugs you currently take.

For Payment. The Plans may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care Providers may be paid

according to the Plans' terms. For example, the Plans may receive and maintain information about surgery you received to enable the Plans to process a hospital's claim for Reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The Plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plans' participants receive their health benefits. For example, the Plans may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plans may also combine health information about many Plan participants and disclose it to members of the General Assembly of Virginia in summary fashion so they can decide what coverages the Plans should provide. The Plans will remove information that identifies you from health information disclosed to these individuals so it may be used without these individuals learning who the specific participants are. The Plans may also use or disclose your PHI for underwriting and premium rating purposes, but the Plans do not use or disclose your PHI that is genetic information for underwriting purposes.

To The Department of Human Resource Management. The Plans may disclose your PHI to designated Department of Human Resource Management personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Director of the Department of Human Resource Management and/or the Director of the Office of Contracts and Finance. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: may not be disclosed by the Plans to any employer or to be used for any employment-related actions and decisions or in connection with any other employee benefit plans.

To a Business Associate. Certain services are provided to the Plans by third party administrators known as "business associates." For example, the Plans may input information about your health care treatment into an electronic claims processing system maintained by the Plans' business associate so your claim may be paid. In so doing, the Plans will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plans will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The Plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The Plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The Plans may use or disclose to your family member, other relative, your close personal friend, or other person you identify, PHI directly relevant to such person's involvement in your health care or payment related to your care. The Plans may use or disclose your PHI to notify a family member, your personal representative, or another person responsible for your care, about your location, condition, or death. In these situations, when you are present and not incapacitated, they will either (1) obtain your agreement; (2) provide you with an opportunity to disagree to the use or disclosure; or (3) using reasonable judgment, infer from the circumstances that you do not object to the disclosure. If you are not present, or you cannot agree or disagree to the use or disclosure due to incapacity or Emergency circumstances, the Plans may use professional judgment to determine that the disclosure is in your best

interests and disclose PHI relevant to such person's involvement in your care, payment related to your health care, or notification purposes. If you are deceased, the Plans may disclose PHI to such individuals involved in your care or payment for your health care prior to your death the PHI that is relevant to the individual's involvement, unless you have previously instructed the Plan otherwise.

As Required by Law. The Plans will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

The Plans may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the Plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The Plans may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

Workers' Compensation. The Plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws or other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the Plans may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The Plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The Plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with Medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The Plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain circumstances, the Plans may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The Plans may release your PHI to facilitate specified government functions related to: (1) intelligence, counterintelligence and other national security activities authorized by law; (2) the provision of protective services to the President of the United States, members of the U.S. government

or foreign heads of state, or to conduct special investigations; and (3) correctional institutions and other law enforcement custodial situations.

Organ and Tissue Donation. If you are an organ donor, the Plans may release Medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funerals Directors. The Plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plans may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Assist Victims of Abuse, Neglect, or Domestic Violence. The Plans may, under certain circumstances, disclose PHI about you if you are reasonably believed to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive such reports.

Certain Government-Approved Research Activities. The Plans may use or disclose PHI about you to research as provided under the Privacy Rule.

Breach of Unsecured PHI. You must be notified in the event of a breach of unsecured PHI that affects you. A "breach" is the acquisition, access, use, or disclosure of PHI in a manner that compromises the security or privacy of the PHI. If you are affected by a breach of unsecured PHI you must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

Your Rights Regarding Health Information About You

Your rights regarding the health information the Plans maintain about you are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI, including your PHI maintained in an electronic format. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. If your PHI is available in an electronic format, you may request access electronically.

To inspect and copy health information maintained by the Plans, submit your request in writing to the Privacy Official. The Plans may charge a fee for the cost of copying and/or mailing your request. But, this fee must be limited to the cost of labor involved in responding to your request if you requested access to an electronic health record. In limited circumstances, the Plans may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the Plans have about you is incorrect or incomplete, you may ask the Plans to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, send a detailed request in writing to the Claims Administrator. You must provide the reason(s) to support your request. The Plans may deny your request if you ask the Plans to amend health information that was: accurate and complete, not created by the Plans; not part of the health information kept by or for the Plans; or not information that you would be permitted to inspect and copy.

Right to An Accounting of Disclosures. You have the right to request an "accounting of disclosures," including a disclosure involving an electronic health record. This is a list of

disclosures of your PHI that the Plans have made to others, except those necessary to carry out health care treatment, payment, or operations (Note: does not apply to electronic health records); disclosures made to you; or in certain other situations.

To request an accounting of disclosures, submit your request in writing to the Privacy Official. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested (three years in the case of a disclosure involving an electronic health record).

Right to Request Restrictions. You have the right to request a restriction on the health information the Plans use or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plans not use or disclose information about a surgery you had.

To request restrictions, make your request in writing to the Plan Administrator. You must advise us: (1) what information you want to limit; (2) whether you want to limit the Plans' use, disclosure, or both; and (3) to whom you want the limit(s) to apply.

Note: ***The Plans are not required to agree to your request.***

Right to Request Confidential Communications. You have the right to request that the Plans communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plans send you explanation of benefits (EOB) forms about your benefit claims to a specified address.

To request confidential communications, make your request in writing to the Plan Administrator. The Plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Disclosure of PHI to a Personal Representative. You may request that the Plans disclose your PHI to your personal representative. A personal representative is an individual you designate to act on your behalf and make decisions about your health care. If you want the Plans to disclose your PHI to your personal representative, submit a written statement giving the Plan permission to release your PHI to your personal representative and documentation that this individual qualifies as your personal representative under state law, such as a power of attorney. Submit this request in writing to the appropriate privacy contact listed below. The Plans may elect not to treat a person as your personal representation if (1) the Plans reasonably believe that you have been or may be subject to domestic violence, abuse or neglect by such person, or treating such person as your personal representative could endanger you; or (2) the Plans, using professional judgment, decide that it is not in your best interest to treat the person as your personal representative.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice, even if you received this Notice previously or agreed to receive this Notice electronically. You may write to the Plan Administrator to request a written copy of this notice at any time.

Changes to this Notice

The Plans reserve the right to change this notice at any time and to make the revised or changed notice effective for health information the Plans already have about you, as well as any information the Plans receive in the future. The Plans will post a copy of the current notice at the Department of Human Resource Management.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Plan Administrator at the address listed below. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred.

Note: **You will *not be penalized or retaliated against for filing a complaint.***

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plans will be made only with your written authorization. Your written authorization is also required for:

- Most uses or disclosures of psychotherapy notes (where appropriate);
- Uses or disclosures of your health information for marketing purposes. Marketing does not include communications, involving no financial remuneration, for certain treatment or health care operations purposes, such as communications about entities that participate in a health plan network, health plan enhancements or replacements, case management or care coordination, or contacting individuals about treatment alternatives; and
- Disclosures of PHI that are considered a sale

  If you authorize the Plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

If you have any questions about this notice, please contact:

The Department of Human Resource Management
LODA Health Benefits Plans
101 North 14th Street, 12th Floor
Richmond, VA 23219
804-225-2131

Notice Effective Date: January 1, 2003, as revised effective July 1, 2017.

Commonwealth of Virginia's Health Benefits Programs Nondiscrimination Notice

The LODA (Line of Duty Act) Health Benefits Plans (the Plans) comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plans:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (such as large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the LODA Health Benefits Plans Benefits Administrator.

If you believe that the Plans have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

LODA Health Benefits Plans
Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, Virginia 23219-3657
Please mark the envelope - **Confidential**

To use email, send your complaint to **loda@dhrm.virginia.gov**

To use facsimile, fax your complaint to **804-371-0231**.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the LODA Health Benefits Plans Benefits Administrator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

OTHER FEDERAL NOTICES

Genetic Information Nondiscrimination Act of 2008 (GINA)
Effective January 1, 2010, GINA prohibits health coverage and employment discrimination against a Plan participant based on his or her genetic information. Genetic information generally includes family Medical history and information about an individual's and his or her family members' genetic tests and genetic services.

Under GINA, group health plans and health insurers providing group health plan coverage cannot use genetic information with respect to eligibility, premiums or contribution amounts. They also cannot request, require or purchase genetic information prior to a person's enrollment in a health care plan or request or require genetic testing of an individual for underwriting purposes. The availability of genetic testing and the results of any genetic testing you undergo will be treated as confidential, as required by GINA and the Health Insurance Portability and Accountability Act of 1996.

The Newborns' and Mothers' Health Protection Act
Maternity hospital stays under the Plan will be covered for a minimum of 48 hours following a vaginal delivery, or 96 hours for a cesarean section delivery. These minimums are set by a federal law called The Newborns' and Mothers' Protection Act. However, the Plan may pay for a shorter Stay if the attending Provider (physician, nurse midwife or physician's assistant) discharges the mother or newborn earlier, after consulting with the mother.

Other provisions of this law:
- The level of benefits for any portion of the hospital Stay that extends beyond 48 hours (or 96 hours) cannot be less favorable to the mother or newborn than the earlier portion of the stay.
- The Plans cannot require Precertification for a Stay of up to 48 or 96 hours, as described above – although stays beyond those times must be precertified if the Plans include a Precertification requirement.

Women's Health and Cancer Rights
If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1988 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:
- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and the reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other Medical and surgical benefits provided under these Plans. These Plans are required to provide you with a notice of your rights under WHCRA when you enroll, and then once each year.

STATEMENT OF ERISA RIGHTS

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

You may examine, without charge, at your Plan Administrator's office and at other specified locations, all plan documents. These include insurance contracts, copies of all documents filed by the plan with the Department of Labor (such as detailed annual reports), and plan descriptions.

You may obtain copies of all plan documents and other plan information by writing to your Plan Administrator. The administrator may make a reasonable charge for the copies.

Note: ERISA generally does not apply to church plans or to governmental plans (such as plans sponsored by city, county, or state governments, or by public school systems).

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.

- No one may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
- If your claim for a welfare benefit is denied in whole or in part, you may receive a written explanation of the reason for the denial.
- You have the right to have the plan administrator review and reconsider your claim.

Enforcement of ERISA rights
Under ERISA, there are steps to enforce the above rights. For instance:

- If you request materials 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 or an appeal of a coverage decision, which is denied or ignored, in whole or in part, you may file suit in a state or federal court.
- If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court decides who pays 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, if, for example, it finds your claim to be frivolous.

Assistance
If you have questions about your plan, contact your Plan Administrator. If you have questions about this statement about your rights under ERISA, contact the nearest Area Office of the Employee Benefits Security Administration, Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.