Medicare Supplement Plan for Retirees of Washington University
Enrolled in Medicare Part A and Part B

Administered by Anthem Blue Cross Blue Shield

Effective January 1, 2015

The following benefit plan summary does not describe all benefits and is not part of the Plan Document. The Plan Document issued to your group sponsor contains plan details and controls over the information in this booklet. You have the right to review the Plan Document during regular business hours.
# Table of Contents

## Section 1: Introduction
- About ABCBS ............................................. 1
- This Booklet ................................................ 1
- Your ABCBS ID Card ................................ 1
- Medicare-Eligible Charges and Assignments ........................... 1
- ABCBS’s Arrangements With Providers and Others ....................... 1
- Permission to Obtain and Release Information .......................... 2

## Section 2: Eligibility for Coverage
- To Be Eligible for Coverage ................................ 3
- Contribution Requirements .................................... 3
- If You Change Your Name or Address .......................... 3
- Annual Open Enrollment Period .................................. 3
- Termination of Coverage ....................................... 3
- Medical Entitlement .......................................... 3
- Death or Divorce .............................................. 3

## Section 3: Terms You May Want to Know
- Definitions ................................................... 5

## Section 4: How Your Plan Works
- Your Medicare Supplement Benefits ............................ 7
- Supplemental Benefits for Part A (Hospital Insurance) .......... 7
- Supplemental Benefits for Part B (Medical Insurance) .......... 8
- Prescription Drugs Are Not Covered .......................... 8
- Blood .................................................................. 8
- Benefits for Emergency Care And Care Outside the U.S. ....... 8
- Summary of What You Pay for Medical Benefits .................. 8

## Section 5: What Is Not Covered Under Your Medicare Supplement Plan
- Exclusions .................................................... 10

## Section 6: When and How to File Claims
- Always Show Your Cards ..................................... 11
- Most Claims Should Be Filed by Your Provider .......... 11
- If You Need to File ......................................... 11
- Your Right to Appeal ........................................ 12

## Section 7: You Have Rights and Responsibilities
- Notice of Privacy Practices .................................... 15
- Statement of ERISA Rights .................................... 15
- Guarantee Association Notice .................................. 16

## Section 8: Administrative Information
- Plan Information ............................................. 17
Section 1: Introduction

About ABCBS
Anthem Blue Cross Blue Shield (ABCBS) has been serving the health benefit needs of thousands of Missourians for more than 60 years. ABCBS offers and administers health benefit plans for more Missourians than any other company.

Your Medicare Supplement plan is self-funded. ABCBS does not underwrite benefits and is not the plan administrator for your health benefits plan.

ABCBS provides administrative services for your health care plan on behalf of your plan sponsor. Part of the administrative service is to provide a benefit plan and a provider network, utilization review and appeal service, and a pharmacy benefit management service.

This Booklet
This booklet is designed to help you understand your health care plan. Your specific benefits are shown in Section 4, “How Your Plan Works.”

In this booklet, the terms “you” and “your” refer to the person who applied for coverage (the participant) and, in most cases, to the participant’s covered family members (beneficiaries). The participant and beneficiaries are often called “members” in ABCBS materials.

“We,” “us” and “our” mean your plan sponsor, unless the information relates to claims payment or other administrative services that ABCBS performs. ABCBS acts on behalf of your plan sponsor.

“Care” can mean health care services, equipment, supplies or hospital accommodations provided or used to diagnose or treat a condition.

Your ABCBS ID Card
Be sure to show both your Medicare Card and your Anthem Blue Cross Blue Shield (ABCBS) Identification Card to the physician, hospital or other provider of care any time you receive health care services.

Medicare-Eligible Charges and Assignments
This plan is designed to supplement your Medicare Part A and B benefits. This does not mean that covered services will always be paid in full by Medicare or by this plan.

Payment by Medicare for your doctor’s and medical supplier’s charges will be based on the “Medicare-eligible” charge.

The Medicare-eligible charge is the amount Medicare determines is the reasonable charge for a service or supply.

You may be responsible for charges above the eligible amount if the doctor or supplier doesn’t accept “assignment.” Accepting “assignment” means the doctor or supplier agrees to accept the Medicare-eligible charge as payment in full and cannot bill you for any charge in excess of the eligible amount.

You should ask your physicians and suppliers if they will accept assignment.

(A supplier is a person or organization, other than a doctor or health care facility, that furnishes equipment or services covered by Medicare. For example, ambulance firms and independent laboratories are suppliers.)

Even if your doctor does not accept assignment, the federal government has placed limits on the amount physicians can charge. This is called the “charge limit.”

A physician cannot charge you more than the charge limit set by the government. For more information, call your local Social Security office or Medicare carrier.

ABCBS’s Arrangements With Providers and Others
Some contracts that ABCBS and its affiliates have with health care providers, vendors, administrators and other service providers allow for the payment of fees, allowances, incentives, adjustments, settlements, discounts and/or rebates to ABCBS and its affiliates. These payments are for the sole benefit of ABCBS and its affiliates and may be used to help offset administrative costs.

ABCBS or one of its affiliates receives a claim, it calculates charges that are the member’s responsibility (copayments, etc.) without regard to these payments.

For covered prescription drugs, ABCBS or one of its affiliates may make agreements with other companies that are designed to reduce prescription drug costs in order to benefit you and the members covered under your health plan, us and others. As part of these agreements, ABCBS or one of its affiliates may receive rebates and other compensation, directly or indirectly from these other companies, based on the number of covered prescription drugs purchased under your health plan and other services
or information provided to, or for, these companies or in connection with your health plan.

ABCBS or one of its affiliates will retain any rebates or compensation received from these other companies. Members achieve savings based only on the reduction in costs at the time members purchase prescription drugs.

The contracts or arrangements that ABCBS or one of its affiliates have with health care providers may also include financial incentives to promote effective medical management practices. Under these incentive agreements, the payments made to health care providers are partially based on how well they manage patient care. Factors that may be considered include patient satisfaction surveys, quality performance measures and the number of services members receive.

Permission to Obtain and Release Information

To determine benefits, ABCBS often needs information from others. Your plan has authorized ABCBS to obtain information about you. ABCBS or one of its affiliates has the right to collect personal health and financial information about you and any family members listed on the application form and to use and disclose that information as described in the “Notice of Privacy Practices” statement. (See Section 2 for this Notice.)

Your plan sponsor and ABCBS are not responsible for any fees charged for providing information to ABCBS.

Also, requests for information may delay processing of claims. To avoid delays, ABCBS sometimes processes claims without requesting information. Later ABCBS may learn that the care should not have been covered. If so, ABCBS may request a refund of the benefits paid.

You can notify ABCBS in writing that it cannot obtain or release information concerning you — other than information needed for payment of benefits and other health insurance operations or as required by law. Any restrictions on obtaining or releasing information to which ABCBS agrees would not apply to actions taken before its agreement with you.

Also, if you refuse to consent to release information to us, ABCBS may have to deny your claims.
Section 2: Eligibility for Coverage

To Be Eligible for Coverage
To be eligible for this coverage, you must be a Washington University retiree, age 65 or over, and enrolled in both Medicare Part A and Part B.

If you are a Washington University retiree under age 65, you are eligible for this coverage if you are enrolled in Medicare Part A and Part B due to disability.

A Washington University retiree’s covered Spouse or Domestic Partner who is enrolled in both Medicare Part A and Part B is also eligible for coverage.

A surviving Spouse or Domestic Partner of a Washington University retiree or employee who met the eligibility requirements for retiree benefits, who was enrolled in a Washington University health plan as of the retiree’s/employee’s date of death, is eligible for this coverage if enrolled in both Medicare Part A and Part B.

Family members of a surviving spouse or Domestic Partner of a Washington University retiree or employee are not eligible for coverage under this plan unless they were also eligible dependents of the Washington University retiree/employee as of the retiree’s/employee’s date of death.

Contribution Requirements
You are responsible for the entire cost of this coverage for both yourself and for your Spouse/Domestic Partner, if covered.

If You Change Your Name or Address
If you change your name or address, please contact the Washington University Benefits Office immediately. Up-to-date records help us to serve you better.

Family Status Change
Due to IRS regulations, no additions, changes, or terminations in your health or dental-only coverage will be accepted outside the Open Enrollment Period unless you experience a family status change and submit the required forms with 31 days of that change (62 days for the birth or adoption of a child). Examples of a family status change include, but are not limited to:

— Marriage, divorce, legal separation, or annulment
— Gaining a dependent by birth, legal adoption of a child, or addition of a stepchild
— Losing a Spouse/Domestic Partner or dependent through death or if a dependent becomes ineligible
— Changes in your, your spouse’s/domestic partner’s, or your dependent’s employment status
— Your spouse’s/domestic partner’s health open enrollment

Annual Open Enrollment Period
During the Open Enrollment Period, eligible participants may enroll themselves and their eligible family members in coverage. Washington University determines the period of time that is the Open Enrollment Period.

Termination of Coverage
We may terminate this coverage by notifying you in writing at least 31 days prior to the designated termination date.

We may cancel or refuse to renew this coverage if a material misrepresentation is made by you or with your knowledge within two years of your effective date.

We may also cancel this coverage if you do not pay your premium in a timely manner.

Your coverage will not be canceled because of your age, the condition of your health or the number of claims you file.

Also, if in the future you or your spouse becomes ineligible for Medicare, this coverage will end for that person.

If you choose to cancel this coverage, your coverage will end on the last day of the month in which Washington University receives a written request from you to terminate the coverage, or any later date stated in your request, as long as you pay the premium to that date.

Medicaid Entitlement
If you request, we will suspend this plan for up to 24 months during your entitlement to benefits under Medicaid. You must notify us within 90 days of this entitlement.

We will reinstate you in this plan if you request it within 90 days from when the entitlement ends. When you are reinstated, you will not have a waiting period, your coverage will be substantially equal to what it was before the suspension, and your premiums will be the same as what they would have been had you not been suspended.

Death or Divorce
If you (the participant) die, coverage under this plan will end automatically as of the date of death.
However, a covered spouse may maintain continuous coverage through ABCBS by applying in his or her own name through Washington University (if eligible in accordance with the formal Washington University retiree plan).

If you and your spouse divorce, your spouse may be eligible to continue coverage under COBRA.
Section 3: Terms You May Want to Know

Benefits: The coverage your health insurance plan provides.

Benefit Period: A period specified by Part A of Medicare for inpatient hospital care or care in a skilled nursing facility. Successive periods of inpatient care shall be considered to be continuous and to constitute a single Benefit Period for purposes of this plan if discharge from and readmission to a hospital or skilled nursing facility occurs within a 60-day period.

Calendar Year: A period of one year starting January 1.

Cooperative Payment: The 20 percent of the remaining reasonable charges for services or materials, supplies, etc., payable by the participant under Title XVIII, Part B, Section 1833, of the Social Security Act as amended, after the Part B deductible has been satisfied.

Covered Person: A Washington University retiree or Spouse/Domestic Partner who is eligible for and enrolled in this plan.

Domestic Partner: A person of either gender to whom the subscriber is not legally married, but who lives with the Subscriber in a non-platonic relationship and with whom the Subscriber has an emotional and financial commitment. The Subscriber must complete a Domestic Partner Declaration and provide proof of residence for the Domestic Partner to the Employer.

Emergency Care: Care needed immediately because of a condition arising suddenly and requiring immediate care because of danger to the life or health of the patient.

Hospital: An institution that, on an inpatient basis, is primarily engaged in providing on its premises, diagnostic and therapeutic facilities, or surgical or medical diagnosis, treatment and care of injured or sick persons by or under the supervision of a staff of one or more physicians, and that continuously provides 24-hour nursing service by or under the supervision of graduate registered nurses.

The institution must be duly licensed and be operating as an acute care, general hospital pursuant to the laws of the state in that it is located.

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Convalescent, nursing, rest or extended care facilities, and facilities operated exclusively for treatment of the aged, drug addicts or alcoholics, are not hospitals, even if such a facility is operated as a separate institution by a hospital.

1. A “participating hospital” agrees to accept the payment amount determined by the Claims Administrator. A participating hospital will bill the Claims Administrator directly for care that is a benefit under this plan and will accept the payment amount as payment in full for that care.

2. A “non-participating hospital” is any hospital that is not a participating hospital.

Home Health Services: Care provided on a visiting basis at the participant’s home and defined as “home health services” under Title XVIII, Part B of the Social Security Act. This includes part-time nursing care by or under the supervision of a registered nurse; physical, occupational or speech therapy; medical social services; visits by a home health aide; and medical supplies other than drugs and biologicals, prescribed or authorized by a physician.

Hospital Care or Care in a Skilled Nursing Facility: Care provided in a hospital or skilled nursing facility, including:

1. Inpatient Care. Care and services rendered to a covered person admitted to a hospital or to a skilled nursing facility as a bed patient.

2. Outpatient Care. Care in the emergency room or outpatient department of a hospital.

3. Emergency Care. Hospital care at a non-Medicare participating facility if it was not safe for the participant to travel to a participating hospital.

Insured: Any person enrolled in Medicare Parts A and Part B who has made application to and has been accepted for issuance of this plan.

Licensed Health Care Professional: A physician or other professional provider duly licensed to render care that is a benefit under this plan.

Lifetime Reserve: The additional Medicare benefit days which may be used after 90 days of hospital care in any benefit period have been received. Unlike the days of hospital care that renew when a benefit period ends, these additional days are not renewable.

Medical Care: Care in or out of the hospital and outpatient hospital treatment, including physician services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment.

Medically Necessary Care: Care that is necessary according to Medicare guidelines.
Medicare: The Part A and/or Part B programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Medicare-Eligible Services: Services and supplies covered by Medicare, and provided to a covered person who is eligible for Medicare Part A and Part B.

Medicare-Participating Facility: A hospital or skilled nursing facility that has an agreement with the government to serve as a provider of services under Medicare.

Member: A retired former employee of the plan sponsor enrolled in Medicare Part A and Part B and who has applied for and been accepted for coverage by the plan sponsor.

Non-Medicare Participating Facility: Any hospital or skilled nursing facility that does not meet the guidelines for or chooses not to participate as a Medicare participating facility.

Participant: A Washington University retiree or Spouse/Domestic Partner who is enrolled in Medicare Part A and Part B and is eligible for and enrolled in this plan.

Physician: A duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), who is not an intern, a resident or in training.

1. Participating Physician. A physician who is registered as a participating physician and agrees to accept the allowed amounts as determined by the ABCBS. A participating physician agrees to bill the ABCBS directly for care which is a benefit, and agrees to accept the allowed amounts as payments in full for that care. The company will make its payments, if any, for the care directly to its participating physician.


Prescription Drugs: Injectable insulin, and drugs and medicines that legally require written prescription by a physician, doctor of dental surgery, doctor of dental Medicine or podiatrist and that must be dispensed by a licensed registered pharmacist or physician, but only including drugs and medicines approved by the Food and Drug Administration, and not including any drugs and medicines that constitute investigational or obsolete care.

Provider: A physician, hospital, ambulatory surgical center, home health care agency or skilled nursing facility; a supplier of ambulance services, durable medical equipment, home infusion therapy or home respiratory therapy; and other types of licensed or certified health care professionals or health care facilities.

Reasonable Charge or Reasonable Cost: The amount that Medicare determines is the reasonable charge for a service or supply that is a benefit under this plan.

Skilled Nursing Facility (SNF): Any institution or a distinct part thereof, such as a special wing or ward of a Hospital, that meets requirements for participation in Medicare as established by the Secretary of Health and Human Services and/or is licensed by the state in which it operates as a Skilled Nursing Facility.

1. A “participating skilled nursing facility” agrees to accept the payment amount determined by the Claims Administrator. A participating skilled nursing facility will bill the Claims Administrator directly for care that is a benefit under this plan and will accept the payment amount as payment in full for that care.

2. A “non-participating skilled nursing facility” is any facility that is not a participating skilled nursing facility.

Spouse: The person to whom the Subscriber is legally married.

Totally Disabled: A participant or a dependent who had been actively working is considered totally disabled if he or she is unable, because of illness or injury, to perform the material and substantial duties of his or her job. A retiree or a dependent who had not been actively working is considered totally disabled if he or she is unable, because of an illness or injury, to perform the usual and ordinary activities of a person of like age. (In any of these situations, the disability may be either permanent or temporary.)

Types of Membership:

1. Individual. Any individual (one person) eligible for and enrolled in Medicare Parts A and B.

2. Two-Person. An Insured and Spouse/Domestic Partner both eligible for and enrolled in Medicare Parts A and B.
Section 4: How Your Plan Works

Your Medicare Supplement Benefits

Medicare Supplement coverage helps pay your medical expenses that are not covered by Medicare. It provides supplemental benefits for Medicare Hospital Insurance, known as Part A, and for Medicare Medical Insurance, known as Part B.

Your Medicare Supplement plan also provides services and supplies not covered by Medicare.

For more information about your Medicare benefits, contact your local Social Security office and ask for a copy of “Your Medicare Handbook.”

Supplemental Benefits for Part A (Hospital Insurance)

Your Medicare Supplement coverage supplements Part A benefits by helping to pay covered charges not paid by Medicare for:

— inpatient care in Medicare-participating hospitals,
— inpatient care in Medicare-participating state-licensed skilled nursing facilities and certain other approved facilities.

(A Medicare-participating hospital or skilled nursing facility is one that has an agreement with the government to serve as a provider of services under Medicare.)

Most hospitals and many skilled nursing facilities are Medicare-participating facilities. If you’re not sure whether a facility is participating with Medicare, call the facility and ask. You can also ask your local Social Security office.

Hospital Care

Medicare Part A will help pay for almost all medically necessary services prescribed by a doctor and provided to an inpatient in a Medicare-participating hospital. Medicare will help pay for inpatient care for up to 90 days each benefit period.

(A benefit period is a period of time that begins the first day you receive Medicare-covered services in a hospital and ends when you have been out of a hospital or skilled nursing facility for 60 days in a row. Then a new benefit period starts the next time you go into a hospital.)

Part A Deductible: When you first go into a Medicare-participating hospital each benefit period, Medicare will not pay a certain amount of the charges. This is called the Part A deductible, and the amount usually increases each year. The deductible only has to be paid once each benefit period.

Your Medicare Supplement plan will pay the Part A deductible amount that Medicare will not pay each benefit period.

After Deductible, 60 Days Covered in Full: Other than the Part A deductible, Medicare will pay the full cost of almost all medically necessary inpatient hospital services for up to 60 days each benefit period.

Coverage for 61-90 Days: For inpatient care from the 61st to the 90th day each benefit period, Medicare will cover all eligible services except for a certain amount each day. This amount is called a daily copayment (cooperative payment) amount, and the amount usually increases each year.

This plan will pay the daily copayment amount Medicare will not pay for inpatient care from the 61st day through 90th day each benefit period.

Lifetime Reserve Days: Medicare will help pay for 60 additional days of hospital care once during your lifetime. These extra days are called reserve days. These days do not renew. They can only be used once.

When you choose to use any of these days, Medicare will pay all but a set amount each day. This is also called a daily copayment amount, and it, too, usually increases each year.

This plan will pay the daily copayment amount that Medicare will not pay for your 60 reserve days.

When Medicare increases the Part A deductible or daily copayment amounts, the amount that your Medicare Supplement plan will pay increases also. So these amounts continue to be covered in full under your plan.

Additional Hospital Care: In addition, after all Medicare benefits have been used, including your reserve days, this plan will pay 90% of all Medicare-eligible inpatient hospital charges for a given period of time. For accidents and all illnesses except mental and emotional disorders and drug and alcoholic conditions, benefits will be paid for up to 365 additional days each benefit period. For mental and emotional disorders and drug and alcoholic conditions, benefits will be paid for up to 30 additional days in any consecutive 12 months.

(A Medicare-eligible charge is a medically necessary expense that would have been covered by Medicare if all Medicare benefits had not been used.)
Skilled Nursing Facility Care

20 Days Covered in Full: If you meet the conditions established by Medicare, Medicare will pay the full cost of almost all medically necessary care received in a Medicare-participating skilled nursing facility for the first 20 days.

Coverage for 21-100 Days: After 20 days, Medicare will pay all but a set amount (the daily copayment amount) for care from the 21st through the 100th day. This amount has been increasing each year.

This plan will pay the daily copayment amount not paid by Medicare for care from the 21st day through the 100th day in a licensed skilled nursing facility.

(A skilled nursing facility is a special kind of nursing facility that provides relatively short-term care for recently hospitalized patients who continue to need full-time skilled care, but not long-term custodial care.)

Supplemental Benefits for Part B (Medical Insurance)

This part of your Medicare Supplement plan helps pay covered charges not paid by Medicare for doctor’s services and outpatient hospital and out-of-hospital services and supplies.

Part B Deductible: Under Part B, you must pay a certain amount in “eligible” charges each calendar year before Medicare covers any charges. This amount is your Part B deductible.

This plan will pay your Part B deductible amount each year.

80% After the Deductible: After your eligible charges equal the Part B deductible in a calendar year, Medicare will generally pay 80% of eligible charges for any additional covered services you receive that year.

This plan will pay the remaining 20% of eligible charges not paid by Medicare.

Remember, the eligible charge is the amount Medicare determines is the reasonable charge for a particular service. Your doctor or supplier may charge more than the eligible charge. Neither Medicare nor this plan will pay for charges in excess of the eligible charges.

(See “Medicare-Eligible Charges and Assignment” in Section 1.)

Also, this plan will not pay any amount in excess of the amount Medicare will pay for certain services, such as outpatient treatment of mental illness and physical therapy provided by an independent therapist.

Prescription Drugs Are Not Covered

Note: This Medicare Supplement plan does not provide benefits for prescription drugs.

You may want to enroll in a Medicare Part D prescription drug plan.

Blood

Medicare will pay for all except the first three pints of blood under Part A and Part B.

This Medicare Supplement plan will pay the reasonable cost of the first three pints of blood covered under Part A and Part B, unless there is no charge because the blood is replaced.

Benefits for Emergency Care and Care Outside the U.S.

In addition to its supplemental benefits for Medicare Part A and Part B, this plan pays the extra “first-dollar-benefits” described below. With first-dollar benefits, you do not have to satisfy a deductible first.

In a non-Medicare participating hospital, either in or outside the United States, this plan will pay 75% of covered charges for inpatient emergency care and for outpatient treatment of accidental injury, minor surgery and diagnostic studies and tests.

This plan will also pay $350 per year for covered physician services received outside the United States.

(Emergency care is care needed immediately because of an injury or illness of sudden and unexpected onset.)
### Summary of What You Pay for Medical Care

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>1st of month coincident with becoming eligible for Medicare coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preexisting Conditions</td>
<td>Preexisting conditions are covered from your effective date.</td>
</tr>
<tr>
<td>Surviving Spouse Coverage Continues</td>
<td>Surviving-spouse coverage will continue. Your spouse must contact the Benefits Office</td>
</tr>
<tr>
<td>Medicare Annual Deductibles</td>
<td>Medicare Parts A and B require that each covered individual meet an annual deductible under both Part A and Part B before Medicare starts paying benefits each calendar year. This plan will pay the Part A and Part B deductible amounts that Medicare will not pay each calendar year.</td>
</tr>
<tr>
<td>Foreign Travel</td>
<td>Pays up to $350 a year for physicians. Pays 75% of covered inpatient charges</td>
</tr>
<tr>
<td>Medicare-Participating Providers</td>
<td>To receive benefits through Medicare and this plan, you must use providers that participate in Medicare.</td>
</tr>
<tr>
<td>Office-Visit Fee</td>
<td>Medicare will generally pay 80% of Medicare-eligible charges.* This plan will pay the remaining 20% of Medicare-eligible charges not paid by Medicare.</td>
</tr>
<tr>
<td>Surgery</td>
<td>Medicare will generally pay 80% of Medicare-eligible charges.* This plan will pay the remaining 20% of Medicare-eligible charges not paid by Medicare.</td>
</tr>
<tr>
<td>Lab Tests and X-Ray Services</td>
<td>Medicare will generally pay 80% of Medicare-eligible charges.* This plan will pay the remaining 20% of Medicare-eligible charges not paid by Medicare.</td>
</tr>
<tr>
<td>Hospital Inpatient Care</td>
<td>Other than the Part A deductible, Medicare will help pay for almost all medically necessary inpatient hospital services for up to 60 days each benefit period, in a Medicare-participating hospital. For inpatient care from the 61st to the 90th day each benefit period, Medicare will cover all eligible services except for a certain amount each day. This amount is called a daily copayment amount, and the amount usually increases each year. Your ABCBS Medicare Supplement Plan will pay the daily copayment amount that Medicare will not pay for inpatient care. After all Medicare hospitalization benefits have been used, including your lifetime reserve days (60 days), this plan will pay 90% of all Medicare-eligible inpatient hospital charges for 365 additional days each benefit period, for accidents and all illnesses except mental illness and substance abuse. For mental illness and substance abuse, this plan will pay for up to 30 additional days in any consecutive 12 months.</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>Medicare covers the first 100 days in full. No days are covered after the first 100 days.</td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>If you meet the conditions established by Medicare, Medicare will pay the full cost of almost all medically necessary care received in a Medicare-participating skilled nursing facility during the first 20 days. Medicare will pay all but a set amount (the daily copayment amount) for care from the 21st day through the 100th day. This plan will pay the daily copayment amount Medicare will not pay for the 21st day through the 100th day.</td>
</tr>
</tbody>
</table>

*Note: A Medicare-eligible charge is the amount Medicare determines as the reasonable charge for a particular service. Your provider may charge more than the eligible charge. Neither Medicare nor your ABCBS Medicare Supplement Plan will pay charges above the Medicare-eligible charge.
Your Medicare Supplement plan does not provide benefits for the following:

- Care and services not expressly specified in this Summary Plan Description or in excess of those provided in this Description.

- Any care or service not provided for under Medicare Part A or Part B, unless otherwise specified in this Description.
Section 6: When and How to File Claims

Always Show Your Cards

Whenever you receive care from a hospital, physician or some other provider of covered health care services or supplies, be sure to show both your Medicare Card and your ABCBS ID card. If you lose your ABCBS ID card, please contact Client Services at 1-800-843-6447.

Most Claims Should Be Filed by Your Provider

Since Medicare is your primary plan, your claims must be submitted to Medicare first (unless the services or supplies are not covered by Medicare).

The federal government requires most health care providers and suppliers to file your Medicare claims for you. So in most cases, you shouldn’t need to file a claim to obtain your Medicare benefits.

Also, in most cases, you shouldn’t need to file your own claim to receive the benefits of this plan. If the charges are for services or supplies that are covered by Medicare, the Medicare carrier will usually forward your medical claim to us, and we will provide the benefits of this plan automatically in most cases.

You should not submit a claim for the benefits of this plan if your Explanation of Medicare Benefits (EOMB) states, in part: “This information is being sent to your private insurer.” This note means that the Medicare carrier is submitting your claim to us so we can provide the benefits of this plan. If this note is on your EOMB, please do not submit a claim to us. Also, please let your providers of care know that they should not submit your claim to us. When we receive duplicate claims, this increases costs.

If You Need to File

If your Explanation of Medicare Benefits (EOMB) does not indicate that your claims have been referred for supplemental claims processing, or if the services or supplies are not covered by Medicare, you should file your own claim.

If Covered by Medicare

If you receive services or supplies that are covered by Medicare, you can file a claim for your Medicare Supplement benefits without completing a claim form.

Simply write your name and your Anthem Blue Cross Blue Shield Identification Number on the EOMB you receive and send it to:

Medical Claims
Anthem Blue Cross and Blue Shield
PO Box 105187
Atlanta, GA 30348 – 5187

You may want to make a copy of the EOMB form for your records before you send the original to us.

If you do not receive an EOMB, when you receive an itemized bill that shows the amount Medicare paid, simply write your name and your ABCBS Identification Number on the bill and send it to us at the address above.

If Not Covered by Medicare

If you receive services or supplies that are not covered by Medicare but are covered by this plan, you should send a completed claim form and copies of your itemized bills to us.

For example, if your plan includes benefits for emergency care while traveling in a foreign country, you will probably need to file your own claim.

If you do not have an ABCBS claim form, please use the phone number on the back of your ABCBS ID Card to call us and request one.

- For faster processing, don’t wait until the end of the year to file. Claims should be filed as soon as possible after covered services or supplies are provided. Claims must be filed no later than 15 months after the date the services or supplies were received.

- Complete separate claim forms for yourself and your spouse if you submit charges for both.

- Filing instructions are provided on the back of the claim form. Please read the instructions before completing the form.

- The claim form must be filled out completely and accurately. Each question must be checked “yes” or “no.” If a question is not answered, or if “yes” is checked but the additional information requested on the form is not provided, your claim may have to be returned to you. This delays processing.

- When you write in your Identification Number on the claim form, be sure to include the first three digits.

- Only itemized bills are acceptable. Each bill must show:
  — your name,
  — the name and address of the provider of care,
— a description of each service and the date provided,
— a diagnosis, and
— the charge for each service.

Please submit your original bills (not copies) with your completed claim form. You may want to make a copy of the claim form and itemized bills for your records. Your bills cannot be returned to you after your claim is processed.

Canceled checks, cash register receipts and non-itemized bills that show only “balance-due” or “for professional services rendered” are not acceptable and must be returned to you.

Send all bills for covered services not previously submitted, including those used to meet any deductible for specific services.

Mail the completed form and your itemized bills to the address shown on the claim form.

Your Right to Appeal

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

- A pre-service claim is a claim for benefits under the plan for which you have not received services or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.
- You will be provided with a written notice of the denial; and
- You are entitled to a full and fair review of the denial.

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

Notice of Adverse Benefit Determination

If your claim is denied, the Administrator’s notice of adverse benefit determination (denial) will include:

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

For claims involving urgent/concurrent care:

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

Appeals

You have the right to appeal an adverse benefit determination. You or your authorized representative must ask for an appeal within 180 calendar days after you are notified of a denial. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Administrator’s review of your appeal will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit decision.

The Administrator offers a mandatory level of appeal. The timeframe allowed for the Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may request an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Administrator’s decision, can be sent between the Administrator and you by phone, fax or other similar method. To ask for an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Administrator by calling 1-800-325-3377 or fax the request to 1-877-333-7488. If you prefer, you can send your request in writing to: Anthem Blue Cross and Blue Shield, Grievances and Appeals, 3536 East Sunshine, Suite 132, Springfield, MO 65809. Provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider’s name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be handled on an expedited basis.
All other requests for appeals should be sent in writing by you or your authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). Send written appeals to: Anthem Blue Cross and Blue Shield, Attn: Grievances and Appeals, P.O. Box 105568, Atlanta, GA 30348-5568. You must include your member ID number when submitting an appeal. Upon request, the Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. “Relevant” means that the document, record, or other information:

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

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

**Appeal Review**

When the Administrator considers your appeal, the Administrator will not rely upon the initial benefit determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination.

**Notification of Appeal Outcome**

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

If you appeal any other pre-service claim, Washington University will notify you of the outcome of the appeal within 15 days after receipt of your appeal request.

If you appeal a post-service claim, Washington University will notify you of the outcome of the appeal within 30 days after receipt of your appeal request.

**Appeal Denial**

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

**Mandatory Second Level Appeals**

If you are not satisfied with the Administrator’s first level appeal decision, a mandatory second level appeal is available. If you would like to ask for a mandatory second level appeal, please write to Washington University Attn: Health Plan Appeals, 7509 Forsyth, Suite 150, St. Louis, MO 63105. If you prefer, you can fax your request to 314-935-8198. Your request must be submitted within 60 calendar days of the denial of the first level appeal.

If your second level appeal is for a pre-service claim, Washington University will notify you of the outcome of the appeal within 15 days after receipt of your appeal request.

If your second level appeal is for a post-service claim, Washington University will notify you of the outcome of the appeal within 30 days after receipt of your appeal request.

**External Review**

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

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

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

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

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider’s name;
- the service or supply for which approval of benefits was sought; and
- Any reasons why the appeal should be processed on a more expedited basis.
All other requests for External Review should be submitted in writing unless the Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to: Anthem Blue Cross and Blue Shield, Attn: Grievances and Appeals, P.O. Box 105568; Atlanta, GA 30348-5568. You must include your member ID number when submitting a request for external review.

External Review is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.
Section 7: You Have Rights and Responsibilities

Protected Health Information Under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy Regulations issued under HIPAA contain provisions designed to protect the privacy of certain individually identifiable health information. Your Employer’s group health plan has a responsibility under the HIPAA Privacy Regulations to provide you with a Notice of Privacy Practices. This notice sets forth the Employer’s rules regarding the disclosure of your information and details about a number of individual rights you have under the Privacy Regulations. The Administrator of your Employer’s Plan has also adopted a number of privacy practices and has described those in its Privacy Notice. If you would like a copy of the Administrator’s Notice, contact the customer service number on the back of your Identification Card.

Statement of ERISA Rights

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a participant in this plan, to certain rights and protections.

Your Rights and Protections

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the plan administrator’s office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements, and copies of all applicable documents filed with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Duties of People Who Operate Your Plan

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 plan administrator is the “fiduciary” of your plan and has the duty to administer your plan prudently and in the interest of you and other plan participants and beneficiaries. The fiduciaries have discretionary authority to determine eligibility for benefits and to interpret terms of the plan.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the fiduciaries review and reconsider your claim.

The Role of ABCBS

Anthem Blue Cross Blue Shield (ABCBS) provides certain administrative services, including payment of claims. ABCBS does not underwrite the financial risk and is not liable for guaranteeing benefits.

You may write to Anthem Blue Cross Blue Shield at the following address:

1831 Chestnut
St. Louis, MO 63103-2275

You May File Suit

Under ERISA, you can take steps to enforce your rights. For instance, if you request materials about the plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the plan administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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 will decide who should pay the court costs and legal fees. If you succeed, 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 (e.g., if it finds your claim is frivolous).

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, 200 Constitution Ave. N.W., Washington, D.C. 20210.

**Guarantee Association Notice**

The plan document is not covered by Missouri Life and Health Insurance Guaranty Association.

If the company providing this plan is unable to meet its obligation by reason of insolvency or financial impairment, the fund(s) of the Missouri Life and Health Insurance Guaranty Association will not be available to protect the certificate or contract holder or his/her beneficiaries, payees or assignees.
Section 8: Administration Information

The following information was updated 2/20/012.

For your rights under the Employee Retirement Income Security Act of 1974 (ERISA), see “Statement of ERISA Rights” on page 54.

Plan Name: Comprehensive Medical Plan for Employees of Washington University

This is a group health benefit plan established for employees of:

Company Name: Washington University
And Address: 7509 Forsyth Blvd., Suite 150
St. Louis, MO 63105

Plan Number: 502
Type of Plan: Health Plan
Type of Administration: Contract Administrator

Employer ID Number: 43-0653611
Plan’s Policy Year Ends: 12/31

Plan Administrator: Health Plan Administrator
Washington University
7509 Forsyth Blvd., Suite 150
St. Louis, MO 63105
(314) 362-9341

Agent of Legal Service: Agent for Legal Process – Health Plans
Washington University
6600 S. Euclid, Box 8037
St. Louis, MO 63110
(314) 747-5518

Service of legal process may also be made upon a plan trustee/administrator.

The Plan Is: Contributory
Plan Funding: Self-Funded

Underwriter: N.A.

Employee contributions are held in the Washington University Comprehensive Medical Plan trust maintained by Mellon Bank and are retained in the Washington University general assets until paid through reimbursement or directly to the covered employee's health care provider for covered expenses.

Retirees and their dependents become eligible for this coverage on the first of the month coincident with or following date of eligibility for Medicare Part A and Part B coverage. Coverage ends on the last day of the month eligibility ends; or, if this program is terminated by the employer, coverage ends on the effective date of termination.

For information about eligibility, termination of benefits and how to appeal a claim:

See the previous sections of this booklet.
Anthem Blue Cross Blue Shield only provides administrative services for this plan and does not underwrite benefits for this group plan.

- **If you have questions about your medical benefits or claims,** call ABCBS Client Services at **1-800-843-6447**.

  The Client Services hours are 7 a.m. to 6 p.m., Monday through Friday.

  To see information about your claims, go to [www.Anthem.com](http://www.Anthem.com).

- **Always show your Medicare card and your health benefit plan’s ID Card** — also referred to as your BlueCard — each time you receive health care services.

- **If you change your name or address,** please notify your plan administrator and call Client Services immediately at **1-800-843-6447**.

- **If you are to receive inpatient care, outpatient surgery, home health care, or skilled nursing facility care from providers other than ABCBS network providers,** call for precertification at **1-800-992-5498**.

1831 Chestnut Street, St. Louis, MO 63103-2275