

# A Guide to Your Benefits

*You've made a good decision in choosing  
BluePreferred*

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**Colorado Health Plan Description Form**  
**Anthem Blue Cross and Blue Shield**  
**BluePreferred PPO for Group**  
**30-1500D - 80%- Prescription Drug 15/40/60**  
**Effective July 1, 2009**

**PART A: TYPE OF COVERAGE**

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED? <sup>1</sup>	Yes, but the patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

**PART B: SUMMARY OF BENEFITS**

**Important Note:** This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance options reflect the amount the carrier will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. DEDUCTIBLE TYPE <sup>2</sup>	Benefit Year	Benefit Year
4a. ANNUAL DEDUCTIBLE <sup>2s</sup>		
a) Individual <sup>2b</sup>	\$1,500	\$3,000
b) Family <sup>2c</sup>	\$4,500 aggregate	\$9,000 aggregate
5. OUT-OF-POCKET ANNUAL MAXIMUM <sup>3</sup>		
a) Individual	\$3,000, excludes deductible and copayments.	\$6,000, excludes deductible.
b) Family	\$6,000 aggregate, excludes deductible and copayments.	\$12,000 aggregate, excludes deductible.
c) Is deductible included in the out-of-pocket maximum?	No	No
	Some covered services have a maximum numbers of days, visits or dollar amounts allowed during a calendar year. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied.	Some covered services have a maximum numbers of days, visits or dollar amounts allowed during a calendar year. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$2,000,000 per member for most covered services, in and out-of-network. Infertility diagnostic services have a lifetime maximum payment of \$2,000 per member in and out-of-network combined. Bariatric surgery has a lifetime maximum benefit of \$15,000 per member for services received from a designated facility; total lifetime benefit shall not exceed \$15,000 per member in and out-of-network combined. Major organ transplants have a lifetime maximum benefit of \$1,000,000 per transplant per member.	\$2,000,000 per member for most covered services, in and out-of-network combined. Infertility diagnostic services have a lifetime maximum benefit of \$2,000 per member in and out-of-network combined. Bariatric surgery has a lifetime maximum benefit of \$1,500 per member for services received from a facility that is not a designated facility; total lifetime maximum that shall not exceed \$15,000 per member in and out-of-network combined.
7A. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list of current providers.	All providers licensed or certified to provide covered benefits

	IN-NETWORK	OUT-OF-NETWORK
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes
8. MEDICAL OFFICE VISITS <sup>4</sup> a) Primary Care Providers  b) Specialist	\$30 copayment per visit. Covered person pays 20% after deductible for all other services (e.g. laboratory and x-ray services)  \$30 copayment per visit. Covered person pays 20% after deductible for all other services (e.g. laboratory and x-ray services)	Covered person pays 40% after deductible  Covered person pays 40% after deductible
9. PREVENTIVE CARE a) Children's services  b) Adults' services	Up to age 13, \$30 copayment per office visit. Covered person pays 20% not subject to deductible for all other services (e.g. laboratory and x-ray services) includes immunizations.  \$30 copayment per visit for routine exam. Covered person pays 20% after deductible for all other services (e.g., laboratory and x-ray services). In addition, mammogram screening and prostate screening are covered and are not subject to deductible or coinsurance. \$100 copayment for routine colonoscopy (no age or frequency limits)	Up to age 13, covered person pays 40%, not subject to deductible, includes immunizations.  Not covered except for mammogram screening and prostate screening, which are not subject to deductible or coinsurance.  In addition colonoscopies are covered (no age or frequency limits) covered person pays 40% not subject to deductible.
10. MATERNITY a) Prenatal care  b) Delivery & inpatient well baby care <sup>5</sup>	\$30 copayment for first prenatal care office visit/delivery from the physician. Covered person pays 20% for all other services (e.g., laboratory and x-ray services).  Covered person pays 20% after deductible for facility services.	Covered person pays 40% after deductible for prenatal care office visits/delivery from the physician  Covered person pays 40% after deductible for facility services.

	IN-NETWORK	OUT-OF-NETWORK
<p><b>11. PRESCRIPTION DRUGS</b> Level of coverage and restrictions on prescriptions<sup>6</sup></p> <p>a) Inpatient care</p> <p>b) Outpatient care</p> <p>c) Prescription Mail Service</p>	<p>Covered person pays 20% after deductible</p> <p><b>Retail Pharmacy Drugs</b> - Tier 1 \$15 copayment, tier 2 \$40 copayment, tier 3 \$60 copayment, per prescription at a participating pharmacy up to a 30-day supply. Diabetic medication and supplies will be covered under the tier 1 \$15 copayment.</p> <p><b>Specialty Pharmacy Drugs</b> - Tier 1 \$15 copayment, tier 2 \$40 copayment, tier 3 \$60 copayment, per prescription from our Specialty Pharmacy up to a 30-day supply. Specialty Pharmacy Drugs are not available at a retail pharmacy or from a mail-order pharmacy.</p> <p><b>Mail-Order Pharmacy Drugs</b> - Tier 1 \$15 copayment, tier 2 \$80 copayment, tier 3 \$120 copayment, per prescription through the mail-order service up to a 90-day supply. Specialty pharmacy drugs are not available through the mail-order service. Diabetic medication and supplies will be covered under the tier 1 \$15 copayment.</p> <p><b>The following applies to b) and c) above:</b> Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem, up to \$500 per lifetime per member.</p> <p>Prescription Drugs will always be dispensed as ordered by your provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket expenses. You may request, or your provider may order, the brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and brand-name drug, in addition to your tier 1 copayment. By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness. Anthem reserves the right, at our discretion, to remove certain higher cost generic drugs from this policy. For drugs on our approved list, call customer service at 1-877-811-3106.</p>	<p>Covered person pays 40% after deductible</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<b>12. INPATIENT HOSPITAL</b>	Covered person pays 20% after deductible	Covered person pays 40% after deductible
<b>13. OUTPATIENT/AMBULATORY SURGERY</b>	Covered person pays 20% after deductible	Covered person pays 40% after deductible

	IN-NETWORK	OUT-OF-NETWORK
14. <b>DIAGNOSTICS</b> a) Laboratory & x-ray  b) MRI, nuclear medicine, and other high-tech services	Covered person pays 20% after deductible  Covered person pays 20% after deductible	Covered person pays 40% after deductible  Covered person pays 40% after deductible
15. <b>EMERGENCY CARE</b> <sup>7,8</sup>	Covered person pays 20% after deductible	Covered person pays 20% after deductible
16. <b>AMBULANCE</b>	Covered person pays 20% after deductible	Covered person pays 20% after deductible
17. <b>URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	\$60 copayment per office visit. Covered person pays 20% after deductible for all other services (e.g., laboratory and x-ray services)	Covered person pays 40% after deductible
18. <b>BIOLOGICALLY-BASED MENTAL ILLNESS CARE</b> <sup>9</sup>	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
19. <b>OTHER MENTAL HEALTH CARE</b> a) Inpatient care  b) Outpatient care	Covered person pays 50% after deductible. Limited to 45 full or 90 partial days per benefit year for other mental health care except as listed below.  Covered person pays 50% after deductible. Limited to 30 visits with no less than \$1,000 in benefits per benefit year for other mental health care except as listed below.	Not covered  Not covered
	For other mental disorders of post-traumatic stress disorder, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder and general anxiety disorder, coverage is no less extensive than the coverage provided for any other physical illness. Anorexia nervosa and bulimia nervosa, to the extent those diagnoses are treated on an outpatient, day treatment, and inpatient basis (residential treatment is excluded), are covered no less extensively than the coverage provided for any other physical illness.	
20. <b>ALCOHOL &amp; SUBSTANCE ABUSE</b> a)	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
21. <b>PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY</b> a) Inpatient  b) Outpatient	Covered person pays 20% after deductible. Limited to 30 non-acute inpatient days per benefit year combined in and out-of-network.  Covered person pays 20% after deductible. Limited to 20 visits per benefit year each for physical, occupational and speech therapy combined in and out-of-network, from birth until the third birthday benefits are provided as required by applicable law.	Covered person pays 40% after deductible. Limited to 30 non-acute inpatient days per benefit year combined in and out-of-network.  Covered person pays 40% after deductible. Limited to 20 visits per benefit year each for physical, occupational and speech therapy combined in and out-of-network, from birth until the third birthday benefits are provided as required by applicable law.

	IN-NETWORK	OUT-OF-NETWORK
22. DURABLE MEDICAL EQUIPMENT	Covered person pays 20% after deductible. Limited to a maximum benefit of \$1,000 per benefit year. The \$1,000 maximum benefit is combined to include Durable Medical Equipment (line 22) and Oxygen (line 23). For prosthetic devices (arms and legs), benefits are provided with the same deductible and coinsurance as provided by Medicare. Prosthetic devices for arms and legs are not subject to, or limited by, the maximum benefit of \$1,000.	Not covered
23. OXYGEN	Covered person pays 20% after deductible with benefits limited to a maximum benefit of \$1,000 per benefit year combined with durable medical equipment (see line 22).	Not covered
24. ORGAN TRANSPLANTS	Covered person pays 20% after deductible. Benefits are limited to \$1,000,000 payment per transplant with a maximum benefit of \$10,000 for transportation and lodging and maximum payment of \$25,000 for donor services.	Not Covered
25. HOME HEALTH CARE	Covered person pays 20% after deductible. Limited to 60 visits per benefit year.	Not covered
26. HOSPICE CARE a) Inpatient Care b) Outpatient care	Covered person pays 20% after deductible.  Covered person pays 20% after deductible.	Covered person pays 40% after deductible.  Covered person pays 40% after deductible.
27. SKILLED NURSING FACILITY CARE	Covered person pays 20% after deductible. Limited to 100 days per benefit year combined in and out-of-network.	Covered person pays 40% after deductible. Limited to 100 days per benefit year combined in and out-of-network.
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Vision benefits included in this plan can be found on the separate Anthem Vision Summary Description	Vision benefits included in this plan can be found on the separate Anthem Vision Summary Description
30. CHIROPRACTIC CARE	\$30 copayment per visit. Covered person pays 20% for all other services (e.g., laboratory and x-ray services). Limited to 12 visits per benefit year combined with acupuncture care (see line 31).	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	<b>Acupuncture care:</b> \$30 copayment per visit. Covered person pays 20% for all other services (e.g., laboratory and x-ray services). Limited to 12 visits per benefit year combined with chiropractic care (see line 30).  <b>Hearing Aids</b> Benefit level determined by place of service. Hearing aids are covered up to age 18 and are supplied every 5 years, except as required by law. Members who desire another professional opinion may obtain a second opinion.	Not covered  <b>Hearing Aids</b> Benefit level determined by place of service. Hearing aids are covered up to age 18 and are supplied every 5 years, except as required by law.  Members who desire another professional opinion may obtain a second opinion.

**PART C: LIMITATIONS AND EXCLUSIONS**

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. <sup>10</sup>	6 months for all pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.

**PART D: USING THE PLAN**

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, the member is responsible for obtaining pre-certification unless the provider participates with Anthem Blue Cross and Blue Shield.
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining pre-certification.	Yes, the member is responsible for obtaining pre-certification unless the provider participates with Anthem Blue Cross and Blue Shield.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
39. What is the main customer service number?	1-877-811-3106	
40. Whom do I write/call if I have a complaint or want to file a grievance? <sup>11</sup>	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273 1-877-811-3106	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form # 98904 Group – Large	
43. Does the plan have a binding arbitration clause?	Yes	

<sup>1</sup> "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

<sup>2</sup> "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or "Per Confinement".

<sup>2a</sup> "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

<sup>2b</sup> "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for the allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

<sup>2c</sup> "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "\$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per

family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

<sup>3</sup> "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.

<sup>4</sup> Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

<sup>5</sup> Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together: there are not separate copayments.

<sup>6</sup> Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

<sup>7</sup> "Emergency care" means all services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb threatening emergency existed.

<sup>8</sup> Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

<sup>9</sup> "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

<sup>10</sup> Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

<sup>11</sup> Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

## BLUEVIEW SUMMARY OF VISION BENEFITS

### Anthem West – Exam Only Plan

*This Summary of Vision Benefits outlines the vision benefits available to you through the Anthem Vision Plan. This is a summary of your vision benefit. Please review your benefit certificate for plan details. For eligibility definitions please contact your group administrator.*

**Blue View Vision's Provider Network:** Blue View Vision members have access to approximately 32,500 conveniently located providers nationwide. Blue View Vision contracts with many providers, which including independent optometrists and ophthalmologists as well as well as LensCrafters<sup>SM</sup>, Target Optical and most Sears Optical and Pearle Vision retail locations. Members may call Blue View Vision toll-free at (866) 723-0515 or visit [www.anthem.com](http://www.anthem.com) at any time for provider locations.

For fast, paperless determination and confirmation of benefits, simply schedule an appointment with your *Blue View Vision* Provider and identify yourself as a *Blue View Vision* member.

**Network Provider:** Maximum benefits are achieved when members access their benefits from a *Blue View Vision* Participating Provider. Copayment(s) may apply to in-network benefits.

**Non-Network Provider Reimbursements:** Members may go to a non-participating (non-network) provider and pay the provider directly for services and materials. Members must then submit an original itemized invoice and a copy of the prescription along with the Member's I.D. number to *Blue View Vision* for reimbursement according to the Non-Network Reimbursement schedule identified in this Summary of Vision Benefits.

**Value Added Savings:** *Blue View Vision* providers agree to the Additional Savings Plan that is significantly below retail. Members are able to achieve substantial savings on additional pair purchases, contact lenses, lens treatments, specialized lenses and various other items. Members may save approximately 15% to 40% off retail on these items when they visit a *Blue View Vision* Provider.

**Copayment(s):** Copayment amounts are applicable to Network Provider examinations. Plan allowances must be applied for a single service within a member's benefit year; no remaining balance may be carried forward for another service within the benefit year.

<b>BlueView Vision Benefits</b>	<b>Member Benefit from Network Provider</b>	<b>Non-Network Reimbursement</b>
<b>Vision Examination:</b> Each member is entitled to a comprehensive vision examination by a Network Provider. This is a vision examination only and does not cover a separate contact lens professional fitting fee. <b>Availability : Once every 12 months*</b>	<b>HMO: \$15.00 Copayment</b>  <b>Point-of-Service: \$20.00 Copayment</b>  <b>BluePreferred: \$25 Copayment</b>	<b>Up to \$35.00</b>
<b>Materials: Prescription lenses and frames</b>	<b>Available at Anthem Vision Preferred Prices</b>	<b>Not Covered</b>
<b>Contact Lenses:</b>	<b>Available at Anthem Vision Preferred Prices</b>	<b>Not Covered</b>

\* Benefits are available from the last date of service

### Limitations and Exclusions:

This is a primary vision care benefit and is intended to cover an eye examination only. Materials and any items not covered may be purchased at Preferred Pricing from an Anthem Vision Provider. In addition, the examination is only payable while the group and member coverage is in force.

- Eyeglass Frames
- Eyeglass Lenses
- Elective or Non-Elective Contact Lenses
- Orthoptics or vision training and any supplemental testing.
- Plano (non-prescription) lenses.
- Medical or surgical treatment of the eyes.
- An eye exam or corrective eyewear required by an employer as a condition of employment.
- Any injury or illness covered under Workers' Compensation or similar law, or which is work related.

- Sub-normal vision aids.
- Experimental or non-conventional treatments or devices.
- Safety eyewear.
- In conjunction with other offers or discounts.

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## **Anthem Blue Cross and Blue Shield & HMO Colorado Health Plan Description Form Disclosure Amendment**

Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

Pursuant to Colorado law (C.R.S. §10-16-107(7)(a)), services or supplies for the treatment of Intractable Pain and/or Chronic Pain are not covered.

### **Individual Health Plans**

**This coverage is renewable at your option, except for the following reasons:**

- 1. Non-payment of the required premium;**
- 2. Fraud or intentional misrepresentation of material fact on the part of the plan sponsor;**
- 3. The commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations;**
- 4. The carrier elects to discontinue offering and non-renew all of its individual plans delivered or issued for delivery in Colorado.**

### **Group Health Plans**

Pursuant to Colorado law (C.R.S. §10-16-105(5)(g)(I)), small employers purchasing any health benefit plan other than a Basic Health Benefit Plan, must pay for all benefits mandated by Colorado law, including nonwaivable coverages for: newborn, maternity, pregnancy, childbirth, complications from pregnancy and childbirth, therapies for congenital defects and birth abnormalities, low-dose mammography, mental illness, biologically-based mental illness, the availability of alcoholism treatment, the availability of hospice care, prostate cancer screening, child health supervision services, hospitalization and general anesthesia for dental procedures for dependent children, diabetes, and prosthetic devices.

Pursuant to Colorado law (C.R.S. §10-16-105(5)(g)(II)), small employers purchasing a Basic Health Benefit Plan is waiving coverage for low-dose mammography screening, mental illness, prostate cancer screening, hospitalization and general anesthesia for dental procedures for children, and the availability of treatment for alcoholism. All other state-mandated benefits are included in the Basic Health Benefit Plan.

**This coverage is renewable at your option, except for the following reasons:**

- 1. Non-payment of the required premium;**
- 2. Fraud or intentional misrepresentation of material fact on the part of the plan sponsor;**
- 3. The policyholder fails to comply with participation or contribution rules;**
- 4. The carrier elects to discontinue offering and non-renew all of its small group or large group plans delivered or issued for delivery in Colorado;**
- 5. An employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan;**

6. With respect to group health benefit plans offered through a managed care plan, there are no longer any enrollees who live, reside or work in the service area; or
7. With respect to coverage of an employer that is made available only through one or more bona fide associations, the membership of an employer ceases.

**Important Information for Employers with 50 or Fewer Employees and Business Groups of One:** Rates are calculated based on allowable case characteristics – age bands, geographic location, family size, health status, and claims experience – and will be given within five working days of request. Rates for a specific employer cannot be adjusted due to the duration of coverage of employees or dependents of the small employer. Rates may change based on case characteristics, whenever benefits are changed, or upon giving written notice to the employer not less than 31 days prior to the effective date of the change. New applicants may be subject to pre-existing condition clauses, based on HIPAA requirements. Renewal of health insurance coverage in this class is guaranteed, assuming compliance with underwriting regulations. A Network Access Plan, which describes Anthem Blue Cross and Blue Shield's or HMO Colorado's network standards and evaluation procedures for ensuring provider access is available by calling our customer service department.

**COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS SPECIFIED BY LAW.**

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## Cancer Screenings

At Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Colorado, Inc., we believe cancer screenings provide important preventive care that supports our mission: to improve the health of the people we serve. We cover cancer screenings as described below.

### Pap Tests

All plans provide coverage under the preventive care benefits for a routine annual Pap test and the related office visit. Payment for the routine Pap test is based on the plan's provisions for laboratory services or preventive care service. Payment for the related office visit is based on the plan's preventive care provisions. Under most plans pap tests received out-of-network are not covered since under most plans coverage for preventive care is not covered out-of-network.

### Mammogram Screenings

All plans provide coverage under the preventive care benefits for one routine screening or diagnostic mammogram per year regardless of age (or in accordance with the frequency determined by your provider) for women. Payment for the mammogram screening benefit is based on the plan's provisions for preventive care and is normally not subject to the deductible or coinsurance.

### Prostate Cancer Screenings

All plans provide coverage under the preventive care benefits for one routine prostate cancer screening per year regardless of age (or in accordance with the frequency determined by your provider) for men. Payment for the prostate cancer screening is based on the plan's provisions for preventive exam and laboratory services and is normally not subject to the deductible or coinsurance.

### Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All plans provide coverage for routine colorectal cancer screenings, such as fecal occult blood tests, barium enema, sigmoidoscopies and colonoscopies. Depending on the type of colorectal cancer screening received, payment for the benefit is based on where the services are rendered and if rendered as a screening or medical procedure. Colorectal cancer screenings are covered under preventive care as long as the services provided are for a preventive screening. Our plans do not provide coverage for preventive colorectal cancer screenings involving DNA analysis. Under most plans colorectal cancer screenings received out-of-network are not covered since under most plans coverage for preventive care is not covered out-of-network.

The information above is only a summary of the benefits described. The certificate for each health plan includes important additional information about limitations, exclusions and covered benefits. The Health Plan Description Form for each health plan includes additional information about copayments, deductibles and coinsurance. If you have any questions, please call our customer service department at the phone number on the Health Plan Description Form.

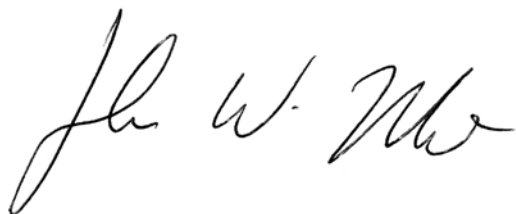
## Welcome

Welcome to Anthem Blue Cross and Blue Shield, where it's Our mission to improve the health of the people We serve. You have enrolled in a quality health benefit program that pays for many health care expenses, including most expenses for Physician and outpatient care, Emergency care and Hospital inpatient care. Throughout this Certificate "Our", "We" and "Us" refer to Anthem Blue Cross and Blue Shield.

This Certificate is a guide to your coverage. Please review this document, as well as any enclosures, to become familiar with benefits, including their limitations and exclusions. Then keep this Certificate in a convenient place for quick reference. By learning how coverage works, you can help make the best use of your health care coverage.

For questions about coverage, please visit Our website or call Our customer service department between the hours of 8:00 a.m. and 5:30 p.m., Monday through Friday. The website address and local and toll-free customer service department numbers located on your *Health Benefit Plan Description Form* or Health Benefit ID Card.

Thank you for selecting Us for your health care coverage. We wish you good health.

A handwritten signature in black ink, appearing to read "John W. Martie". The signature is fluid and cursive, with the first letters of each word being capitalized and prominent.

John Martie  
President and General Manager  
Anthem Blue Cross and Blue Shield

An independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks Blue Cross and Blue Shield Association

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

Acceptance of coverage under this Certificate constitutes acceptance of its terms, conditions, limitations and exclusions. You are bound by the terms of this Certificate.

Health benefit coverage is defined in the following documents:

- This Certificate, the *Health Benefit Plan Description Form* and any amendments or endorsements thereto
- The Enrollment Application and Change Form and any other application for the Subscriber and the Subscriber's Dependents
- The Health Benefit ID Card

In addition, the employer has the following important documents that are part of the terms of the health benefit coverage:

- The Employer Master Application
- The Employer Master Contract between Us and the employer

We, or someone acting on our behalf, will generally determine how benefits will be administered and who is eligible for participation in a manner consistent with the terms of this Certificate. If any question arises about the interpretation of any provision of this Certificate, Our determination will be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigational, or cosmetic. However, you may utilize all applicable Complaint, Grievance and Appeal procedures available under this Certificate.

This Certificate is not a Medicare Supplement policy. If you are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Anthem Blue Cross and Blue Shield. Contact our customer service department for information on how to obtain this guide.

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# Part 1: Anthem Blue Cross and Blue Shield Health Certificate

## YOUR RIGHTS AND RESPONSIBILITIES

### **We are committed to:**

- Recognizing and respecting you as a member.
- Encouraging your open discussions with your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and our network providers.
- Sharing our expectations of you as a member.

### **You have the right to:**

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and Our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: Our organization, any benefit or coverage decisions We (or Our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.

### **You have the responsibility to:**

- Choose a participating primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let Our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.

- Provide Us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with Us.

We are committed to providing quality benefits and customer service to Our members. Benefits and coverage for services provided under the benefit program are governed by the Certificate and not by this Member Rights and Responsibilities statement.

## ABOUT YOUR HEALTH COVERAGE

This is a Preferred Provider Organization (PPO) health insurance coverage, which means you have In-Network (PPO) and Out-of-Network (Non-PPO) benefits. In-Network benefits are services provided to you by a PPO Provider who are participants in Our network as described under the “PPO Providers” heading in this section. Out-of-Network benefits are those provided to you by Providers who do not participate in Our network.

This PPO coverage offers flexibility because you may choose how to use your benefits and control your Out-of-Pocket expenses. When you use your PPO Providers, you receive the highest level of benefits at the lowest cost. The *Health Benefit Plan Description Form* lists payment levels for both In-Network and Out-of-Network care. We publish a directory of PPO and Participating Providers. You can get a directory from your employer or from Us. You may call the customer service number that is listed on your identification card or you may write Us and ask that we send you a directory. You may also search for a Provider on-line at [www.anthem.com](http://www.anthem.com).

### Providers

#### PPO Providers (In-Network)

PPO Providers have entered into a network agreement with Us. Covered Services provided by a PPO Provider are considered In-Network. When you visit an In-Network Provider you have lower Out-of-Pocket expenses. An In-Network Provider will bill Us directly and accept Our Maximum Benefit Allowance as payment in full. The Maximum Benefit Allowance is the dollar amount approved by Us for a specific covered service. Your In-Network Cost Sharing responsibilities to PPO Providers may be found on the *Health Benefit Plan Description Form* under the “In Network” heading. You are responsible for determining if your Provider is an In-Network Provider. You may visit Our website or call Our customer service department for information about Provider network participation.

We make no guarantee that an In-Network Provider will be available for all services and supplies covered under your In-Network coverage. For a limited number of services and supplies, We do not have arrangements with In-Network Providers. Please call Our customer service department for a list of the counties where We do not have In-Network Providers for such services and supplies. If We do not have an In-Network Provider for a Covered Service and We inform you of an alternative for obtaining the services from an In-Network Provider, you may still seek services from an Out-of-Network Provider. However, in some circumstances We may require that you travel a reasonable distance for care from an In-Network Provider to receive services from a PPO or Participating Provider. Under these circumstances, if you knowingly choose to obtain the service from a Non-Participating Provider rather than the PPO or Participating Provider, you will be responsible for paying any charges from the Non-Participating Provider that exceed the Maximum Benefit Allowance paid by Us to the Provider and all Covered Services will be treated as Out-of-Network services. We will not deny or restrict Covered Services solely because you obtain treatment from an Out-of-Network Provider; however, you may have a higher financial responsibility.

#### Non-PPO Providers (Out-of-Network)

Non-PPO Providers are those who have not entered into a network agreement with Us. Services provided by a Non-PPO Provider are considered Out-of-Network. When you visit an Out-of-Network Provider you may have higher Out-of-Pocket expenses. Your Out-of-Network Cost Sharing responsibilities for Non-PPO Providers may be found on the *Health Benefit Plan Description Form* under the “Out-of-Network” heading. Two types of Non-PPO Providers exist:

**Participating Providers** – Non-PPO Providers who have entered into a participating agreement with Us to bill Us directly for covered benefits are Participating Providers. The participating agreement differs from the network agreement that PPO Provider’s sign. Although We have contracted with Participating Providers, they are Out-of-Network Providers. Participating Providers agree to accept Our Maximum Benefit Allowance as payment in full. When benefits are applied, they are paid as out-of-network.

**Non-Participating Providers** – Providers who have not signed agreements with Us are Non-Participating Providers. You must pay more Out-of-Pocket expenses when you visit a Non-Participating Provider. Non-Participating Providers are not required to accept our Maximum Benefit Allowance as payment in full. They may “balance bill” you directly for any amount over Our Maximum Benefit Allowance for a Covered Service. You may be required to pay any difference between Our Maximum Benefit Allowance and the Non-Participating Provider’s Billed Charges. Contact Our customer service department to obtain information on Our reimbursement rate for Non-Participating Providers for specific covered services.

We pay the benefits of this Certificate directly to Participating and Non-Participating Providers, when an assignment of benefits has been authorized. We may require a copy of the assignment of benefits for Our records. If We pay you directly, you are responsible for paying the provider of services for all charges. These payments fulfill our obligation to you for those services.

In addition you are liable for a PPO Provider's, Participating Provider's or Non-Participating Provider's full billed charge for any non-Covered Service or services that the exceed the Benefit Period Maximum.

## **Cost Sharing Requirements**

Cost Sharing refers to how We share the cost of health care services with you. It defines what We are responsible for paying and what you are responsible for paying. You meet your Cost Sharing requirements through the payment of Copayments, Deductibles and Coinsurance (as described below) depending on the terms of your coverage. Cost Sharing requirements depend on the choices you make in accessing services. For example, if you choose to use an In-Network Provider or facility, your out-of-pocket expenses may be less than if you choose an Out-of-Network Provider or facility.

We work with Physicians, Hospitals, pharmacies and other health care Providers to control health care costs. As part of this effort, most Providers who contract with Us agree to control costs by giving discounts to Us. Most other insurers maintain similar arrangements with Providers.

In their contracts, PPO Providers and Participating Providers agree to accept Our Maximum Benefit Allowance as payment in full for Covered Services. We determine a Maximum Benefit Allowance for all procedures performed by Providers.

The contracts between Us and our Providers include a "hold harmless" clause which provides that you cannot be responsible to the Provider for claims owed by Us for health care services covered under this Certificate.

### **Copayment**

Copayments may be required for Covered Services. A Copayment is a predetermined, fixed-dollar amount you must pay to receive a specific service. You are required to pay a Copayment to Providers for specific Covered Service as listed in the *Health Benefit Plan Description Form*. You are responsible for making Copayments directly to the Provider. You must pay fixed-dollar Copayment amounts even after meeting Deductible and/or Coinsurance requirements or Out-of-Pocket Annual Maximum. Copayment amounts do not apply to Deductible and/or Coinsurance requirements. In addition to any Copayment required, you are responsible for any applicable Deductible and/or Coinsurance for additional services received, e.g., laboratory and x-ray services.

### **Deductible**

A Deductible is a specified dollar amount for Covered Services that you must pay within your Benefit Period before We provide benefits. Deductibles do not contribute toward your Out-of-Pocket Annual Maximum. The Deductible amount is listed in the *Health Benefit Plan Description Form*. There are two separate Deductibles: one for In-Network Providers and one for Out-of-Network Providers. Charges from an Out-of-Network Provider cannot be applied toward meeting the In-Network Deductible, and charges from an In-Network Provider cannot be applied toward meeting the Out-of-Network Deductible. If a service is subject to a Copayment, that service is not subject to the Deductible. However, some services which are not subject to Copayment such as laboratory and x-ray services may be subject to the Deductible.

Each Member must meet a separate Deductible. A new Deductible is required for each Benefit Period. The Out-of-Network Deductible applies if We have an In-Network Provider to provide a covered service or supply and you receive the service or supply from an Out-of-Network Provider.

**Family Deductible** - Under a Family Membership, the family Deductible amount is met as follows: When one family Member has satisfied one-third of the family Deductible, that family Member is eligible for benefits. The enrolled remaining family Members are eligible for benefits when they individually satisfy their individual Deductibles or collectively satisfy the balance of the family Deductible.

When no family Member meets one-third of the family Deductible, but the family Members collectively meet the entire family Deductible, then all family Members will be eligible for benefits.

**Portability of Deductible and Out-of-Pocket** - When you change to another one of our Colorado health care coverage's, you may be able to apply the costs of Covered Services incurred while under the previous coverage to satisfy the Deductible requirements for your new coverage, based on the particular benefit design purchased. For details, please contact Our customer service department.

**Prior Deductible Credit** - When you change to Our employer health care coverage from another health insurance carrier's employer coverage, you may be eligible for prior Deductible credit upon initial enrollment. Prior Deductible credit is the term used when claims for services or supplies that were applied toward the current Deductible requirement of the prior carrier are applied to the Deductible requirement of Our coverage. You must request prior Deductible credit and submit written notification of such charges to Our customer service department no later than 180 days following the employer's Effective Date with Us and submit written notification of such charges to Anthem's customer service department at:

Anthem Blue Cross and Blue Shield  
Customer Service  
Attn: Prior Deductible Credit  
Denver, CO 80271-5747

If the documentation provided from the other health insurance carrier gives clear detail that the services were applied to that carrier's In-Network or Out-of-Network Deductible, applicable credit will be given to this coverage In-Network or Out-of-Network Deductible. If the documentation is not available or is unclear as to the prior carrier's application of the Deductible, credit will be given under this coverage to the Out-of-Network Deductible only.

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

You must first meet your required Benefit Period Deductible if applicable, after the Deductible is met We pay a percentage of charges for Covered Services as listed on the *Health Benefit Plan Description Form*. This percentage is called Coinsurance. For some services, you must also pay your required Copayment. After you pay the Copayment, We pay a percentage for Covered Services as listed on the *Health Benefit Plan Description Form*.

Coinsurance is required for Covered Services until the Out-of-Pocket Annual Maximum is reached for your Benefit Period. Until the Out-of-Pocket Annual Maximum is reached, you pay the remaining percentage. Once the Out-of-Pocket Annual Maximum is reached, We pay 100 percent of any remaining eligible charges for the remainder of your Benefit Period. In some cases, the Coinsurance paid for eligible charges for mental health, alcohol and substance abuse care may not be counted toward the Out-of-Pocket Annual Maximum. In-Network and Out-of-Network Coinsurance amounts are separate and do not accumulate toward each other.

The Out-of-Pocket Annual Maximum is designed to protect you from catastrophic health care expenses. Once you and/or your family have satisfied the Out-of-Pocket Annual Maximum, no additional Deductible or Coinsurance will be required for you and/or your family for the remainder of the Benefit Period. Copayments will still be required for the Benefit Period. The Out-of-Pocket Annual maximum is found on the *Health Benefit Plan Description Form*.

NOTE: No one family Member may contribute more than the Member's individual Coinsurance maximum toward meeting the family Out-of-Pocket Annual Maximum. A Member will always be responsible for the difference between billed charges and the Maximum Benefit Allowance for non-participating providers, even after reaching the Out-of-Pocket Annual Maximum for Out-of-Network services.

### **Benefit Period Maximum**

Some Covered Services have a maximum number of days, visits or dollar amounts that We will allow during a Benefit Period. These maximums apply even if you have satisfied the applicable Out-of-Pocket Annual Maximum. See the *Health Benefit Plan Description Form* for those services which have a Benefit Period Maximum.

### **Lifetime Maximum**

We will not pay for Covered Services once you have met the Lifetime Maximum payment allowance. Specific dollar amounts for Lifetime Maximum benefits may be found in the *Health Benefit Plan Description Form*. The Lifetime Maximum payment allowance applies to any payments that We make for Covered Services under this Certificate, or any other product within the same benefit design. As a result, if you change between two or more of Our products within the same benefit design, the same Lifetime Maximum payment allowance applies. If however, you change from coverage under one benefit design to coverage under a different benefit design, a separate and new Lifetime Maximum payment allowance begins with the new coverage.

### **Maximum Benefit Allowance**

Reimbursement for benefits paid under this coverage (except for Out-of-Network Emergency Care and Urgent Care by a Non-Participating Provider) is limited to the Maximum Benefit Allowance. The Maximum Benefit Allowance is the dollar amount determined and approved by Us for Covered Services and procedures. Your applicable Cost Sharing requirements are based on the Maximum Benefit Allowance, not on a Physician's Billed Charges. PPO and Participating Providers have signed agreements to accept the Maximum Benefit Allowance as payment in full.

## **Managed Care Features**

Managed Care is a system of health care delivery with the goal of giving you access to quality, cost effective health care while optimizing utilization and cost of services, and measuring Provider and coverage performance. We use a variety of administrative processes and tools, such as Preauthorization for health care services, Care Management, concurrent Hospital review and Disease Management to help determine the most appropriate use of the health care services available to Our Members. This section of the Certificate explains how these Managed Care features are used and will

guide you through the necessary steps to obtain care. For more information about how you should proceed in case of Emergency care and Urgent care, please see the **COVERED SERVICES** section.

This Certificate does not restrict or interfere with your rights when you are entitled to service and care in a Hospital to select a Hospital or to choose an attending Physician. We require that Physicians hold a valid Physician's license, practice within the scope of that license and be a Member of, or acceptable to, the attending staff and board of directors of the Hospital in which the services are to be provided.

Benefits provided under this coverage do not regulate the amounts charged by Providers of medical care.

### **Transition of Care**

A new Member to this coverage may be receiving ongoing care for a medical condition. Examples of ongoing care include prenatal/obstetrical care, Home Care or Hospice Care. We strive to avoid disruption of a new Member's care through Our transition of care policy. To facilitate the transition of care, you or your Provider must review the reference sheet, complete a Transition of Care Form and submit them to Us for review. You or your Provider may request a reference sheet and Transition of Care Form by calling Our medical management department at 303-831-3238 or 1-800-797-7758.

### **Our Process to Determine If Services are Covered**

To determine if a health service is a covered benefit, We consider whether the service is Medically Necessary and whether the service is Experimental/Investigational, cosmetic or otherwise excluded under this coverage. We use numerous resources, including current peer-reviewed medical literature, Our adopted medical policies and practice guidelines, guidelines obtained from recognized national organizations and professional associations, and consultations with Physician Specialists to determine if a particular service is covered. We will assist you by determining what services are covered under your coverage and what services are excluded from the health coverage. We do not promote or otherwise provide an incentive to our employees or provider reviewers for withholding a benefit approval for covered Medically Necessary services to which you are entitled.

We determine whether services, procedures, supplies or visits are Medically Necessary. Only Medically Necessary services (except as otherwise provided in this Certificate), procedures, supplies or visits are Covered Services. We use medical policy, medical practice guidelines, professional standards and outside medical peer review to determine Medical Necessity. Our medical policy reflects current standards of practice and evaluates medical equipment, treatment and interventions according to an evidence-based review of scientific literature. Medical technology is constantly changing, and We reserve the right to periodically review and update Our medical policies. The benefits, exclusions and limitations of your coverage take precedence over medical policy.

Certain procedures, diagnostic tests, Durable Medical Equipment, Home Care services, Home Intravenous services and medications require Preauthorization. The current list of services requiring Preauthorization is available on Our website. See the **Appropriate Place and Preauthorization** section for additional details.

**Experimental/Investigational and/or Cosmetic Procedures** - We will not pay for any services, procedures, surgeries or supplies that We consider Experimental/Investigational and/or cosmetic. Additionally We will not pay for complications arising from any services, procedures, surgeries or supplies that we consider Experimental/Investigational and/or cosmetic.

### **Appropriate Place and Preauthorization**

Health care services may be provided in an inpatient or outpatient setting, depending on the severity of the medical condition and the services necessary to manage the condition in a given circumstance. We cover care received in both environments provided the care received is a Covered Service and is appropriate to the setting and is Medically Necessary. Examples of Inpatient settings include Hospitals, Skilled Nursing Facilities and Hospice Facilities. Examples of Outpatient settings include Physicians' offices, ambulatory Surgery centers, Home Care and home Hospice settings. Some Covered Services must be received from a designated facility, for example this includes but is not limited to bariatric surgery or human organ transplants. To determine which Covered Services must be received from a designated facility contact customer service. Covered Services received from a non-designated facility may be denied or paid at a lower amount.

Preauthorization is a process We use to determine if a requested service or supply is a covered benefit and that your care is provided in the most medically appropriate setting. The Preauthorization process may set limits on the coverage available under this Certificate. Preauthorization is required before a Hospital admission or before receiving certain procedures or services. Some drugs also require Preauthorization.

The in-state PPO or Participating Provider who schedules an admission or orders the procedures or service is responsible for obtaining Preauthorization. If you are using an in-state Non-Participating Provider or an out-of-state Participating or

Non-Participating Provider, you are responsible for assuring that the Provider has obtained the Preauthorization, and you will be held responsible for the expense of any test, equipment, service or procedure that is not preauthorized. To determine which services require Preauthorization and/or to be sure that Preauthorization has been obtained, you may contact Us.

**Inpatient Admissions** - Admissions for all inpatient stays require Preauthorization and concurrent reviews. Your Provider must call the number for **Provider Authorization** on your Health Benefit ID Card to request Preauthorization. We will review the request for Preauthorization. If the inpatient stay is approved, all benefits available under your coverage are provided. We initially authorize a specified number of days for the inpatient stay and reevaluate such Authorization if additional days are requested by the Provider. This process facilitates your timely discharge or transfer to the appropriate level of care.

Routine newborn care admissions do not require Preauthorization if the newborn is discharged before or on the same date as the mother. If the newborn remains in the Hospital after the mother is discharged, Preauthorization is required for the continued stay.

**Scheduled Admissions** - Your Provider must obtain Preauthorization from us before the admission for all scheduled inpatient admissions as well as concurrent reviews for continued stays that exceed the number of days we have preauthorized. Preauthorization must be requested from Us at least seven days before your admission. We will send written confirmation of Our decision to you and your Provider within two business days of receipt of all necessary information.

**Unscheduled (Emergency) Admissions** - We require notification of an Emergency admission within one business day after the admission. You are responsible for ensuring that We have been notified of the unscheduled admission unless you are unable to do so. Examples of Emergency admissions include admissions involving accidents or the onset of labor in pregnancy. Failure to notify Us may result in denial or reduction of coverage.

**Inpatient admissions include admissions to Acute Care facilities (Hospitals), Long-Term Care Facilities, sub-acute facilities, rehabilitation facilities, Skilled Nursing Care facilities and inpatient Hospice Facilities.**

**Outpatient Procedures** – Many procedures performed on an outpatient basis must be preauthorized. Your Provider must contact Us for Preauthorization. You and Providers may visit Our website at [www.anthem.com](http://www.anthem.com) or call Our customer service department for a list of outpatient procedures and services that require Preauthorization. These services may be performed in a Hospital on an outpatient basis or in a freestanding facility, such as an Ambulatory Surgery center.

If We do **not** grant Preauthorization, you will be held financially responsible for all charges related to that inpatient stay. You or your representative may Appeal Our Preauthorization decision by following the procedure outlined in the **COMPLAINTS, APPEALS AND GRIEVANCES** section.

Upon receipt of a Preauthorization request, We may require additional information to determine the Medical Necessity of the procedure. We will send written confirmation of Our decision to you and your Provider within two business days of Our receipt of all necessary information. The Preauthorization will be valid only for a specific place and period of time. You must obtain the requested service within the time allotted in the Preauthorization and at the place authorized. If the Preauthorization period expires, or if additional services are requested, the Provider must contact Us to request another Authorization.

If a Preauthorization of a requested service meets Medical Necessity criteria, it **does not guarantee** that payment will be allowed. Fraud or abuse, or a subsequent change in eligibility, could cause a denial of payment. When We receive your claim(s), We will review them against the terms of this Certificate.

You or your representative may Appeal our Preauthorization decision by following the procedure outlined in the **COMPLAINTS, APPEALS AND GRIEVANCES** section.

### **Appropriate Length of Stay**

With respect to the payment of benefits We, in conjunction with your Providers, use medical policies and medical care guidelines, such as inpatient and surgical care optimal recovery guidelines to determine the appropriate length of an inpatient Hospital stay for which benefits may be covered. By using these guidelines and increasing your familiarity with your benefit plan, you are more likely to receive the appropriate level of care and achieve favorable outcomes.

**Concurrent Review** - While you are in the Hospital, we will review your medical care to determine if you are receiving appropriate and Medically Necessary Hospital services. If you have an unscheduled admission to the Hospital for any reason, including a medical Emergency, maternity care, or alcohol detoxification, We **require** notification within one business day of the admission to assist with management of the Hospital benefits and planning for covered medical services during hospitalization and after discharge.

At some point during hospitalization, We may determine that further hospitalization is not Medically Necessary. We will advise your attending Physician and the Hospital of this determination. You may elect to remain in the Hospital after you have been notified that continued hospitalization is not Medically Necessary, but We will not pay for services after the recommended date of discharge. We will also send written notification of the decision to your attending Physician and the Hospital. **You will be responsible for all charges incurred after the recommended day of discharge.**

If you or your Provider disagree with a concurrent Hospital review decision, you may Appeal Our decision by following the procedure outlined in the **COMPLAINTS, APPEALS AND GRIEVANCES** section.

**Retrospective Claim Review** - Retrospective claim review consists of reviewing services after the services have been provided to determine if the services were provided as preauthorized, to evaluate claim charges and to review appropriateness of services billed based on available benefits, medical policy and Medical Necessity. We may request and review medical records to assist in payment decisions. If We determine that benefits are not available, We will not pay.

### **Ongoing Care Needs**

Ongoing care is coordinated through services such as Utilization Management, Care Management and Disease Management.

**Utilization Management** - Utilization Management is used to determine if a service is Medically Necessary, delivered in the right setting and for the appropriate length of time. Care is compared to nationally recognized guidelines. This review may be used to determine payment for Covered Services. However, the decision to obtain the service is made solely by you and your Provider regardless of Our decision about reimbursement.

**Care Management** - Care Management is used when illnesses or injuries are so complex that individualized coordination of care is helpful. Examples include the medical management of a transplant candidate or of a patient with a spinal cord injury. In such cases, a Care Manager may work with you and/or your family to help coordinate and facilitate the administration of medical care. A Care Manager may also help organize a safe transition from Hospital to home care. The Care Management program is designed to identify patients as early as possible in their course of medical treatment who may benefit from Care Management and to see that issues pertinent to the case are assessed, addressed, documented, and resolved in a consistent and timely manner.

Depending on the level of Care Management you may need, a Care Manager may be assigned to you. We employ nurses and other medical staff with special training in the coordination of care in complex cases. You may or may not have direct contact with Our Care Manager. This depends on the availability of a liaison at the facility where you are admitted. If a Care Manager is assigned to you, the Care Manager's telephone number will be provided to you so that you may contact the Care Manager with any questions. An assigned Care Manager works with the Providers, you and/or your family to create a plan of care, implement that plan, monitor the use and effectiveness of services, and determine if you are receiving services in a timely manner and in the most appropriate setting. We have full discretion as to which Members We offer Care Management. We may not offer Care Management to all Members of an employer group or to all Members with similar conditions.

Our Care Management program is tailored to the individual. In certain extraordinary circumstances involving intensive Care Management, We may, at our sole discretion, provide benefits for alternate care that are listed as a Covered Service in this Certificate. We may also extend Covered Services beyond the contractual benefit limits of this coverage. We will make these decisions on a case-by-case basis. A decision in one case to provide extended benefits or approve care not listed as a Covered Service in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or cease providing extended benefits or approving care not listed as a Covered Service. In such cases, We will notify you or your representative in writing.

**Disease Management** - Disease Management is used to help coordinate care for you if you have been diagnosed with specific, persistent or chronic conditions. For example We may offer Disease Management programs to Members that have high-risk pregnancies or Members who have been diagnosed with chronic illnesses, such as diabetes, heart disease and asthma.

Disease Management strategy includes working with you to promote self-management and encouraging compliance with the plan of care developed by your Provider. Disease Management emphasizes disease prevention, Member education and coordination of care to avoid acute episodes and/or gradual worsening of the disease over time. Our Disease Management programs are based on the best evidence and practices available in peer-reviewed medical literature. Reports are regularly communicated to your Provider to promote continuity of care.

We may not offer Disease Management programs to all Members who have conditions such as those mentioned above, even if they are in the same employer group. A decision to offer a Disease Management program to you does not obligate Us to offer other programs to you or to offer that program to other Members.

Participation in Disease Management programs is voluntary, and you may choose whether to participate at any time. More complicated conditions may require more intense and/or frequent services.

Our PPO or Participating Provider agreements may include financial incentives or risk-sharing relationships related to the provision of services and encourage participation in Disease Management programs. You may contact your Provider or Us for questions about such incentives or risk-sharing relationships.

**Participation in Ongoing Needs Programs** - There are several ways for you to become involved in one of Our Care Management or Disease Management programs. We can identify Members that We believe may benefit from the programs, or Physicians may refer their patients to Us. You may also contact Us directly by calling Our "Help Line" at (303) 764-7066 or (877) 225-2583. Additional information about Our Disease Management and wellness programs is available on Our website under the "BlueCares for You" heading.

## MEMBERSHIP

### Subscriber

The Subscriber is a Member in whose name the membership is established.

A new employee who has a regular work week as specified in the Employer Master Contract is eligible to enroll for coverage as a Subscriber. The employee must contact the employer for the minimum number of hours that must be worked per week and other requirements to qualify for coverage.

### Dependents

A Subscriber's Dependents may include the following:

- **Legal Spouse.**
- **Common-law Spouse.** The Subscriber must submit a Common-Law Marriage Affidavit for the common-law Spouse to be considered for enrollment. The Common-Law Marriage Affidavit may be obtained through the employer or by calling Our customer service department. All references to spouse in this Certificate include a Common-Law spouse.
- **Same-sex domestic partner.** The Subscriber must submit a Same-Sex Domestic Partner Affidavit for the domestic partner to be considered for enrollment. The Same-Sex Domestic Partner Affidavit may be obtained through the employer or Our customer service department. Same-sex domestic partners are covered. The Subscriber must submit a Same-Sex Domestic Partner Affidavit for the domestic partner to be considered for enrollment.
- **Newborn child.** A newborn child born to the Subscriber or Subscriber's Spouse is covered under the Subscriber's coverage for the first 31 days after birth. If the mother of the newborn child is a Dependent child of the Subscriber, the newborn is **not** covered (see the **Grandchild** heading in this section).

During the first 31-day period after birth, coverage for a newborn child shall consist of Medically Necessary care for injury and sickness, including well child care and treatment of medically diagnosed Congenital Defects and Birth Abnormalities, without regard to the limitations and exclusions applicable to other conditions or procedures of this Certificate. All services provided during the first 31 days of coverage are subject to the Cost Sharing requirements and any benefit maximums applicable to other sicknesses, diseases and conditions otherwise covered.

To continue the newborn child's participation in the coverage beyond the 31-day period after the newborn child's birth, the Subscriber who has a non-family policy must complete and submit an Enrollment Application and Change Form to add the newborn child as a Dependent child to the Subscriber's policy. We must receive the Enrollment Application and Change Form within 31 days after the birth of the child to continue coverage for the 32nd day and thereafter. Subscribers do not need to complete an Enrollment Application and Change Form to add the newborn child as long as they had family coverage that requires no additional premium at the time of birth of the newborn child and they provide Anthem notice within 60 days of the child's birth.

- **Adopted child.** An unmarried child (who has not reached 18 years of age) adopted while the Subscriber or the Subscriber's Spouse is enrolled in coverage will be covered for 31 days after the date of placement for adoption.

"Placement for adoption" means circumstances under which a Subscriber assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates when the legal obligation for support terminates.

To continue the adopted child's participation in the coverage beyond the 31-day period after the adopted child's placement, the Subscriber must complete and submit an Enrollment Application and Change Form to add the adopted child as a Dependent child to the Subscriber's policy. We must receive the Enrollment Application and Change Form within 31 days after the placement of the child for adoption to continue coverage for the 32nd day and thereafter.

- **Dependent child.** An unmarried child (including a stepchild or a disabled child) under 19 years of age may be covered under the terms of this Certificate. At the end of the birth month in which the child turns age 19 the Dependent child is removed from coverage. The Dependent child may qualify as an overage Dependent child as explained below. If the Subscriber or the Subscriber's Spouse is subject to a qualified medical child support order for a Dependent child of the Subscriber or the Subscriber's Spouse, the Dependent child is eligible for coverage, whether the child lives with the Subscriber or the Subscriber's Spouse.
- **Overage Dependent child.** An unmarried child age 19 through age 25 who is financially dependent on the parent or has the same legal residence as the parent may be covered under the terms of this Certificate. At the end of the birth month of the limiting age, the child is automatically removed from the coverage as a Dependent. We may require

substantiating documentation of financial dependency (e.g., a current school class schedule, and proof of registration, proof of tuition payment, or residential status) for an overage Dependent to continue coverage. A completed Overage Dependent Enrollment Request Form and substantiating documentation must be submitted annually for coverage of the overage Dependent child to continue. You may obtain an Overage Dependent Enrollment Request Form from the employer, by calling Our customer service department or by visiting our website at anthem.com. A Dependent child who is no longer eligible for coverage may be eligible for continuation coverage. Information can be found under the heading **Continuation of Coverage** in this section.

- **Disabled Dependent child.** An unmarried child who is 19 years of age or older, medically certified as disabled, and Dependent on the parent may be covered under the terms of this Certificate. We must receive notice of the disability for the disabled Dependent coverage to continue after the Dependent child turns age 19. The Subscriber and the disabled Dependent's Physician must complete and submit a Mentally or Physically Disabled Dependent Form to Us. You may call Our customer service department or visit Our website to obtain a Mentally or Physically Disabled Dependent Form.
- **Grandchild.** A grandchild of a Subscriber or a Subscriber's Spouse is not eligible for coverage unless the Subscriber or the Subscriber's Spouse is the grandchild's court-appointed permanent guardian or has adopted the grandchild. The Subscriber must submit an Enrollment Application and Change Form and evidence of court appointment as permanent guardian or documents evidencing a legal adoption. Another option is to enroll the grandchild under an Individual Membership with Anthem Blue Cross and Blue Shield, subject to its terms and conditions.

### **Medicare-Eligible Members**

Before you become age 65, or if you qualify for Medicare benefits through other circumstances, you are responsible for contacting the local Social Security Administration office to establish Medicare eligibility. You should then contact the Subscriber's employer to discuss coverage options.

For information on how the benefits will be coordinated with Medicare when coverage under this Certificate is continued, see the **DUPLICATE COVERAGE AND COORDINATION OF BENEFITS** heading in the **ADMINISTRATIVE INFORMATION** section.

### **Enrollment Process**

For eligible Subscribers and their eligible Dependents to obtain coverage, the Subscriber must follow Our enrollment process, which details who is eligible and what forms are required for enrollment. Coverage under this Certificate begins as of the Effective Date as indicated in Our files. No services received before that date are covered.

Note: Submission of an Enrollment Application and Change Form does not guarantee your enrollment.

### **Pre-existing Conditions**

With any enrollment, you and your dependents may be subject to a Pre-Existing Condition limitation period as described below. If you have a Pre-Existing Condition, We will not pay the charges for any services related to the Pre-Existing Condition during the limitation period. We reserve the right to review your medical information if a Pre-Existing Condition exists. A Pre-Existing Condition limitation period may be retroactively added if such a Pre-Existing condition exists.

A Pre-Existing Condition is any condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately preceding the date of your enrollment in such a plan, or, if earlier, the first day of the waiting period for such enrollment. Pregnancy is not a Pre-Existing Condition.

We will **not** Pay for services or supplies related to a Pre-Existing Condition for six consecutive months after the date of enrollment or, if earlier, the first day of the waiting period if:

- You enroll as part of a new group with Us and the employer offered no prior health coverage;
- You have no prior coverage within 90 days of the new group Effective Date;
- You have no prior coverage within 90 days of the application for coverage as a new entrant.

We shall not use the waiting period in determining if a condition is a Pre-Existing Condition.

We will **not** Pay for services or supplies related to a Pre-Existing Condition for six consecutive months after the date of enrollment or, if earlier, the first day of the waiting period if:

- You had no prior coverage within 90 days of enrollment and the Member waives coverage with Us initially;

- You did not enroll within 31 days of eligibility;
- You did not enroll within 31 days of a special enrollment period;
- You were not enrolled with the employer's previous health insurance carrier and you enroll as part of a new group with Us.

We will not use the waiting period in determining if a condition is a Pre-Existing Condition.

NOTE: New Entrants who enroll timely (within 31 days of eligibility) and have qualified prior coverage within 90 days of enrollment, are not subject to the Pre-Existing Condition exclusion above. The waiting period is excluded in our determination of qualified prior coverage within 90 days of enrollment.

Special entrants, such as a newly adopted child, newborn child, or children placed for adoption are not subject to the Pre-Existing Condition exclusion above if enrolled within 31 days of eligibility.

### **Enrollment Forms**

The Subscriber must submit an Enrollment Application and Change Form to add any Dependents as Members. Additional forms may be required for special Dependent status. Subscribers may obtain an Enrollment Application and Change Form or any additional forms from their employer, Our customer service department or Our website.

### **Initial Enrollment**

Eligible employees may apply for coverage for themselves and their eligible Dependents by submitting an Enrollment Application and Change Form. We must receive the Enrollment Application and Change Form within 31 days after the date of hire or within 31 days of the expiration of the waiting period, as defined in the employer's new hire policy. The Effective Date of coverage will be determined in accordance with any established waiting period as defined in the Employer Master Contract. The employer will inform the employee of the length of the waiting period.

If you terminate your health insurance coverage with Us, and within the same Benefit Period you enroll in a like-benefit coverage with Us, all covered benefits that have a Benefit Period Maximum and/or Lifetime Maximum will be carried over to the new coverage. For example, if a benefit has a limit of one visit per Benefit Period and you received that benefit under the prior coverage, then you are not eligible under the new coverage for the same benefit until the Benefit Period has expired, as benefits have been exhausted for your Benefit Period.

### **Open Enrollment**

Any eligible employee who has satisfied the waiting period as defined by the employer and did not enroll when initially eligible, as a newly eligible dependent or during a special enrollment may enroll during the employer's annual Open Enrollment period, which is generally a 31-day period before the employer's Anniversary Date. The employer's benefit coordinator will provide the Open Enrollment period date and the Anniversary Date to the eligible employee.

### **Newly Eligible Dependent Enrollment**

A current Subscriber of this coverage may add a Dependent who becomes newly eligible due to a qualifying event. Qualifying events include marriage, birth, placement for adoption or issuance of a court order. We must receive an Enrollment Application and Change Form for the addition of the Dependent within 31 days after the date of the qualifying event. Proof of the qualifying event, e.g., a copy of the marriage certificate or court order, must be attached to the completed Enrollment Application and Change Form. Coverage will be effective on the date of the qualifying event.

When the Subscriber or the Subscriber's Spouse is required by a court or administrative order to provide coverage for an eligible dependent for child support, the eligible Dependent must be enrolled within 31 days of the issuance of such order. We must receive a copy of the court or administrative order with the Enrollment Application and Change Form. If the Subscriber does not enroll the eligible Dependent within 31 days of the issuance of the order, the Subscriber must wait until the next Open Enrollment to enroll the Dependent.

### **Special Enrollment for Eligible Employees and Eligible Dependents**

Special enrollment is available for eligible employees and their eligible Dependents who currently are not enrolled in the employer health coverage with Us. Special enrollment is allowed when a family status change occurs or when the involuntary loss of coverage occurs.

**Family Status Change** - Qualifying events for special enrollment due to a family status change include marriage, divorce, birth, placement for adoption or the issuance of a qualified medical child support order. Coverage with Us will be effective on the date of the qualifying event. When the qualifying event is a birth, and the mother is not previously enrolled, any charges related to labor and delivery due to the birth are not covered. We must receive the completed Enrollment

Application and Change Form within 31 days after the date of the qualifying event. Proof of the qualifying event, e.g., a copy of the marriage certificate or court order, must be attached to the completed Enrollment Application and Change Form.

**Involuntary Loss of Coverage** – For the eligible employee and/or eligible Dependent to qualify for special enrollment due to involuntary loss of the other group health insurance coverage, the loss of coverage must be due to termination of employment, reduction in the number of hours of employment, involuntary termination of Creditable Coverage, death of a Spouse, legal separation or divorce, or termination of employer contributions toward the coverage. If the employee is approved for special enrollment, the coverage with Us will be effective on the day following the loss of other coverage. If COBRA or state continuation coverage is available, enrollment may only be requested after exhausting the COBRA or state continuation coverage.

If the eligible employee and/or the eligible dependents had health insurance coverage elsewhere and voluntarily canceled such coverage, the eligible employee and/or the eligible Dependents do not qualify for special enrollment. However, the eligible employee and/or the eligible Dependents will be allowed to enroll at the employer's annual open enrollment subject to the provisions described in this section under the heading *Late Entrants* in this section.

### **Late Entrants**

To qualify as a late entrant (including voluntary loss of coverage), you may only apply during the employers Open Enrollment period. If approved, coverage will be effective on the employers Anniversary Date. A six-month exclusion for Pre-Existing Condition will apply for late entrants. Please see the **Pre-Existing Condition** heading in the section for details about Pre-Existing Condition limitations.

If you had no prior coverage within 90 days of enrollment you may apply for coverage as a late entrant if you did not request enrollment under one of the following circumstances:

- During the initial enrollment period.
- During the Open Enrollment period.
- As a newly eligible person.
- After a qualifying event for special enrollment occurred.

If you enroll as a late entrant, your eligible dependents seeking coverage at the same time will also be late entrants.

### **Military Service**

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to employees and their Dependents covered under the Plan before the employee leaves for military service:

- The maximum period of coverage of a person under such an election shall be the lesser of;
  - The 24 month period beginning on the date on which the person's absence begins; or
  - The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

### **Multiple Coverage's by Us**

You may have more than one group health insurance policy with Us or any of Our affiliates. To be eligible for a Premium refund, you must notify us within 31 days after the date on which duplicate coverage begins if that duplicate coverage is not desired. If we do not receive notification within this 31-day period, no retroactive refund of Premium payments will be granted; however, you may still be able to terminate the duplicate coverage.

## How to Change Coverage

If a group provides you with multiple health care options, eligible employees may switch coverage for themselves and/or their eligible Dependents to another coverage offered by the group during Open Enrollment.

### Termination

#### Active Policy Termination

Your coverage ends on the first occurrence of one of the following events:

- On the date the Employer Master Contract between the employer and Us is terminated.
- Upon the Subscriber's death.
- When the required Premium has not been paid.
- When you or your employer commits fraud or intentional misrepresentation of material fact.
- When you are no longer eligible for coverage under the terms of the Employer Master Contract.
- When you are deemed a "working aged," as defined by federal law, and Medicare becomes your primary coverage unless you are in a group with fewer than 20 employees.
- When the Subscriber's employer gives Us written notice that the Subscriber is no longer eligible for coverage. Coverage will be terminated on the date of notification or at the end of the month of the qualifying event. We reserve the right to recoup any benefit payments made for dates of service after the termination date.
- When We receive a 31-day advance written notification to cancel coverage for any Member, coverage will end at the end of the month following the 31-day advance written notification period or at the end of the month of the qualifying event. We will credit membership Premium paid in advance on behalf of canceled Members unless We do not receive the cancellation request at least 31 days before the Effective Date of the cancellation.
- When We cease operations.

#### Dependent Coverage Termination

To remove a Dependent from coverage, the Subscriber must complete an Enrollment Application and Change Form 31 days before the Effective Date of the change. If we receive the change notification after the requested Effective Date, the change will be effective on the date We are notified of the change. We reserve the right to recoup any benefit payments made after the termination date.

We will credit membership Premium paid in advance on behalf of the terminated Dependent unless We do not receive the Enrollment Application and Change Form within 31 days before the Effective Date of the change or if We have paid any claims on behalf of the terminated Dependent in the period for which the credit would otherwise be owed to the employer.

Coverage for a Dependent ends on the last day of the month immediately preceding the next monthly Premium due date following receipt of the request or on the first occurrence of one of the following events:

- At the end of the month when the Subscriber notifies Us in writing to cancel coverage for a Dependent.
- When the Dependent child marries or no longer qualifies as a Dependent by definition. Such a Dependent has the right to elect COBRA or state continuation coverage.
- On the date of a final divorce decree or legal separation for a Dependent Spouse. Such a Dependent has the right to elect COBRA or state continuation coverage.
- At the end of the month when legal custody of a child placed for adoption is terminated.

#### Certificate of Creditable Coverage

When your coverage with Us terminates, We will send you a Certificate of Creditable Coverage, which will identify the length of your Creditable Coverage with Us. You may need this Certificate of Creditable Coverage as proof of prior coverage if you enroll with other health care coverage.

#### What We Will Pay for After Termination

Except as provided below, We will not pay for any services provided after your coverage ends even if we preauthorized the service, unless the Provider verified the Member's eligibility within two business days before each service received. Benefits cease on the date your coverage ends as described above. You may be responsible for benefit payments made by Us on your behalf for services provided after your coverage has terminated.

When your coverage is terminated for any reason other than for nonpayment of Premium, fraud or abuse, We shall provide for your continued care if you are being treated at an inpatient facility, until you are discharged or transferred to another level of care, subject to the terms of this Certificate. The discharge date is considered the first date on which you are discharged from the facility or transferred to another level of care. When coverage has been terminated and you receive additional facility care after the discharge date, We will not cover additional services received.

We do **not** cover services received after your date of termination even if:

- We preauthorized the services.
- The services were made necessary by an accident, illness or other event that occurred while coverage was in effect.

## **Continuation of Coverage**

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

When an employee takes time off from work pursuant to the Family and Medical Leave Act, health insurance coverage remains in force but the employee may be required to continue paying the employee's share of the Premium. You may contact your benefit coordinator with your employer for details.

### **State Continuation Eligibility and Notification**

**State Continuation Coverage Eligibility** - Employers with fewer than 20 employees who provide health care coverage for their employees are subject to state law regarding continuation of coverage. The state continuation coverage period will not exceed 18 months for the employee and/or any Dependents. State continuation coverage for employees and their Dependents will commence on the date of the earliest of the following qualifying events:

- The employee's termination of employment. To qualify, you must have been covered by the employer's group health coverage for at least (6) six consecutive months.
- The employee's reduction in working hours resulting in loss of coverage. Reduction in working hours would include circumstances resulting from economic conditions, injury, disability, or chronic health conditions.
- The employee's death.
- Divorce or legal separation of the employee and Spouse.
- Loss of active Dependent status under requirements of the coverage.

**State Continuation Coverage Notification** - Unless termination or reduction in working hours is the qualifying event, a Subscriber, Spouse or Dependent child must notify the employer of their election to continue coverage within 30 days after becoming eligible. The employer is responsible for notifying the Subscriber, Spouse and/or Dependent child of how to elect continuation coverage. Once the employer has provided notice to the Subscriber, Spouse and/or Dependent child, We must receive timely notice from the employer that you are electing state continuation coverage. We must also receive timely payment of appropriate Premium charges from the employer when paid by the Subscriber for you to be eligible for state continuation coverage.

Under state continuation coverage, We must receive notice from the employer and your first Premium payment no later than 30 days after the qualifying event (except that if the employer fails to give timely notice to the Subscriber of the Subscriber's continuation rights, this deadline may be extended to 60 days after the qualifying event). For more details, you may contact your employer.

### **COBRA Eligibility and Notification**

**COBRA Eligibility** - For employers with 20 or more employees, Subscribers and their Dependents who lose eligibility with a group may be eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). You should contact the employer for additional information. COBRA coverage is available for 18, 29 or 36 months, depending on the qualifying event(s), and only if the application and Premium payment requirements of the federal law are met.

COBRA coverage is available to employees and their Dependents for 18 months from the date of the following qualifying events:

- When an employee loses coverage due to a reduction in working hours, including layoffs and strikes.
- When an employee loses coverage due to the voluntary or involuntary termination of employment, including retirement and excluding gross misconduct.

COBRA coverage is available for employees and their Dependents for 29 months from the original qualifying event as described above in the following situation:

- When the Social Security Administration has determined that an employee or Dependent was disabled when coverage was terminated or within 60 days after the coverage was terminated, due to one of the qualifying events above, and the employee or Dependent is still disabled when the 18-month continuation period expires.

COBRA coverage is available for the individuals below for 36 months from the date of the following qualifying events:

- The surviving Spouse and surviving children of a covered employee, when the covered employee dies.
- The covered employee, if the employee became eligible for Medicare benefits before COBRA election.
- Spouses and Dependent children of a covered employee, when the employee and the Spouse separate or divorce.
- Dependent children of the covered employee, when the Dependent children lose eligibility as Dependents.

COBRA coverage is available to children born or placed for adoption during the period of COBRA coverage for the remainder of either the 18-month or 36-month COBRA continuation period. The qualifying event that triggered the COBRA coverage will determine the length of the continuation period for the newborn or adoptee.

**COBRA Notification** - Unless termination or reduction in working hours is the qualifying event, a Subscriber, Spouse or Dependent child must notify the employer of eligibility for COBRA coverage within 60 days after becoming eligible. Once the employer has provided notice to the Subscriber, Spouse and/or Dependent child or the right to elect COBRA, We must receive timely notice from the employer that you are electing COBRA coverage. We must also receive timely payment of appropriate fees or Premium charges for you to be eligible for COBRA.

The COBRA-eligible person has 60 days from the receipt of the employer notification or from the date the prior coverage would otherwise end, whichever is later, to elect COBRA coverage and to inform the employer of the election. To apply for COBRA coverage, the eligible person must complete a COBRA or State Continuation of Coverage Application. The employer must complete the employer section, sign the application and submit it to Us. After electing COBRA coverage, the Subscriber must pay the first fees or Premium due within 45 days. For more details, the Subscriber may contact the employer.

### **Termination of State Continuation Coverage or COBRA**

Your continuation coverage terminates when the continuation period is exhausted. The duration of continuation coverage is detailed under the "State Continuation Eligibility" and "COBRA Eligibility" headings in this action.

Continuation coverage may terminate before the continuation period expires if:

- The Employer Master Contract between the employer and Us is terminated. If the employer selects a replacement group coverage, continuation coverage will continue under the new coverage.
- You fail to pay Premium in a timely manner.
- Under state continuation coverage, you are eligible for another group health insurance policy unless the other coverage excludes a condition covered by the continuation coverage; in that case, the state continuation coverage continues until exhausted or the other coverage covers the excluded condition.
- Under COBRA coverage, you are covered by another group health insurance policy unless the other coverage excludes a condition covered by the COBRA coverage; in that case, the COBRA coverage continues until exhausted or the other coverage covers the excluded condition.
- The date the spouse remarries and becomes eligible for coverage under the new spouse's policy of group health insurance.
- Under COBRA coverage, you become covered by Medicare.
- Your COBRA coverage was extended to 29 months and you are determined under the Social Security Act to no longer be disabled.

- You submit written notice of voluntary cancellation of coverage.

### **Conversion**

When state continuation coverage or COBRA coverage is exhausted, Subscribers and their eligible Dependents who were covered under a group's health insurance policy may apply for group conversion coverage. In the event that state continuation coverage or COBRA coverage is not available, the Subscriber and eligible Dependents must have been covered under the group coverage for at least three months immediately before the termination of group coverage to be eligible for this conversion coverage. **The conversion coverage must be the same type of coverage** as was terminated with Us as the Subscriber's prior coverage under the group policy, and it must be with one of Our Basic or Standard Plans. Conversion coverage is not available if the group health coverage has been discontinued in its entirety. Conversion coverage through Us is not available if the election period occurs after the group has replaced this coverage.

**We must receive an application for group conversion coverage within 31 days after group or continuation coverage is terminated. You must pay the group conversion Premium from the date of such termination.**

Group conversion coverage is not available to former employees of a group and their Dependents in the following situations:

- When an employee is not a group Member because the employee was not covered under the group coverage when the coverage was terminated.
- When the employee's coverage ends because the employee fails to pay any required contributions to premiums.
- When a Dependent was not covered under the group coverage when the employee's coverage was terminated.
- When an employee or Dependent is covered by Medicare Part A and/or Part B at the time of eligibility for group conversion coverage. Please contact Us for coverage options available in this circumstance.
- When the employee or Dependent is covered for similar benefits by another health care benefit policy or is eligible for similar benefits under any arrangement for coverage for individuals in a group, such that the benefits of the other coverage would result in over-insurance according to Our standards.

Note: If you do not want or are not eligible for group conversion coverage, We will consider your application for enrollment in an individual insurance policy under then-available coverage's, rates and benefits. The application is subject to applicable rules for individual coverage.

For groups of 50 or fewer employees, conversion coverage is available to all employees of the group if the group health care coverage is terminated by either Us or the employer for reasons other than replacement with other group health care coverage or fraud and abuse in obtaining and utilizing coverage. Conversion coverage privilege is available even if the group coverage is terminated because the group did not pay Premiums. The conversion coverage will be group coverage under Our Basic or Standard Plans. We will notify each employee of the right to conversion coverage. When the group coverage as a whole is not being terminated; but rather, an individual employee or Dependent's group coverage eligibility is being terminated, conversion coverage is available as described above.

## COVERED SERVICES

This section describes Covered Services available under your health care benefits when provided and billed by eligible Providers. Care must be received from an In-Network Provider to be covered at the In-Network level, except for Emergency Care and Urgent Care. Services which are not received from an In-Network Provider will be considered an Out-of-Network service unless otherwise specified in this Certificate. Not all Covered Services are covered Out-of-Network. See your *Health Benefit Plan Description Form* for any limitations. Covered Services and supplies are only benefits if they are Medically Necessary or preventive, not otherwise excluded under this Certificate as determined by Us and obtained in the manner required by this Certificate. All services must be standard medical practice where they are received for the illness, injury or condition being treated, and they must be legal in the United States. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment by Us. You must contact Us for certain services to be sure that Preauthorization has been obtained by the ordering Provider.

We base our decisions about Preauthorization, Medical Necessity, Experimental/Investigational services and procedures, and new technology on medical policy We develop. We will also consider published peer-reviewed medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations that review the medical effectiveness of health care services and technology.

All Covered Services are subject to the **GENERAL EXCLUSIONS** section of this Certificate. All Covered Services are subject to the other conditions and limitations of this Certificate.

### Preventive Care Services

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Preventive Care Services means care that is rendered to prevent future health problems for a Member who does not exhibit any current symptoms. Coverage for benefits in this section shall meet or exceed those required by law. Coverage may vary based on your age, sex and/or personal history. Preventive care services are developed from national guidelines recommended by such agencies as the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family Physicians. Consult with your Physician for specific health guidelines. See your *Health Benefit Plan Description Form* for any limitations. Preventive Care Services include:

#### Routine Exams and Immunizations

- Routine or periodic exams, e.g., pelvic exams. Exams are covered according to the frequency determined by your Provider. Having the right exams at the right times may help you avoid serious illness;
- Family history, current health problems and lifestyle all affect your risk for disease. Talk to your Provider to determine if you are at high risk for specific diseases and then together determine your appropriate exam schedule;
- Immunizations (including those required for school) and immunizations against cervical cancer to the extent required by applicable law. Immunizations protect you from certain diseases and help prevent epidemics. While immunization risks to your health are low, the risks from disease are high. Both children and adults need immunizations to help keep them healthy;
- Child Health Supervision Services (including limited smoking cessation services) for Dependent children up to age 13, but only to the extent required by applicable law.
- Routine hearing exams.
- Annual medical diabetes eye exams, or in accordance with the frequency determined by your Provider.
- Annual flu shot benefit when you receive a flu shot at your In-Network Provider's office. If it's more convenient to get your flu shot at a flu shot clinic or from an Out-of-Network provider, you may be eligible for reimbursement of some or all of your out of pocket costs. Examples of locations that may provide flu shots and may be considered flu shot clinics include your local pharmacy, your place of employment, a grocery store, Wal-Mart, Walgreens or Costco. There may be additional flu shot clinic locations available to you. For more information on flu shot clinics, and for the reimbursement amount allowed contact customer service or visit our website at [www.anthem.com](http://www.anthem.com). The annual reimbursement is subject to change. Your cost for a flu shot otherwise paid for in full or in part by another party, is not eligible for reimbursement.

#### Routine/Preventive Diagnostic Services

- Routine screening mammogram;

- Routine cytologic screening (pap test);
- Routine prostate specific antigen (PSA) blood test and digital rectal;
- One colorectal cancer examination and related laboratory tests are covered per Benefit Period regardless of age, or in accordance with the frequency determined by your Provider. Routine colonoscopies are also covered regardless of age or frequency limits, see the *Health Benefit Plan Description Form* for payment information. If a colonoscopy is billed with a medical condition then it is subject to the outpatient surgical services payment requirements;
- 
- Routine PKU tests for newborns.

Coverage for benefits in this section shall meet or exceed those required by law.

### **Infertility Services**

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Benefits include Inpatient Services, Outpatient Services, and Physician Office Services for the diagnosis of infertility. Covered Services include only diagnostic and exploratory procedures to determine the cause of infertility. See the *Health Benefit Plan Description Form* for benefit limitations and the lifetime maximum amount.

### **Maternity Services and Newborn Care**

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Maternity Services include Inpatient Services, Outpatient Services and Physician Office Services for normal pregnancy, one routine Ultrasound, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a well newborn, in addition to all Medically Necessary care and treatment of injury and sickness, including medically diagnosed Congenital Defects and Birth Abnormalities for covered newborns.

Coverage for the Inpatient postpartum stay for the mother and the newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. It will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Perinatal Care. If the delivery occurs between 8:00 p.m. and 8:00 a.m., and the 48 or 96 hours have passed, coverage will continue until 8:00 a.m. on the morning following 48 or 96 hours timeframe.

The length of stay shorter than the minimum period of 48 or 96 hours may be allowed if the attending Physician or the Certified Nurse Midwife, with the agreement of the mother, determines further Inpatient postpartum care is not necessary for the mother or newborn child, provided the following criteria are met:

- In the opinion of the attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based on evaluation of:
  - the antepartum, intrapartum, and postpartum course of the mother and infant;
  - the gestational stage, birth weight, and clinical condition of the infant;
  - the demonstrated ability of the mother to care for the infant after discharge; and
  - the availability of post discharge follow-up to verify the condition of the infant after discharge.

**At-home post-delivery follow-up care visits** are covered for you at your residence by a Physician, Nurse or Certified Nurse Midwife when performed no later than seventy-two (72) hours following your and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

- Parent education;
- Physical assessments;
- Assessment of the home support system;
- Assistance and training in breast or bottle feeding; and
- Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary disease and metabolic newborn screening.

At the mother's discretion, this visit may occur at the Physician's office.

We pay for Covered Services from a Provider for therapeutic or elective termination of pregnancy regardless of Medical Necessity.

### **Diabetes Management Services**

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Diabetes Self-Management Training including medical nutrition therapy is covered for an individual with insulin-dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Ordered in writing by a Physician; and
- Provided by a Health Care Professional who is certified, registered or licensed with expertise in diabetes.

Diabetes medical nutrition therapy services are not subject and do not reduce the nutritional therapy limit as listed on the *Health Benefit Plan Description Form*. A diabetes education session must be provided by a Health Care Professional in an Outpatient Facility or in a Physician's office.

Diabetic supplies are covered under the **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT AND APPLIANCES** section and the **PRESCRIPTION DRUG** section.

### **Physician Office Services**

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Physician office services do not include care related to Maternity Services, Emergency and Urgent Care and Mental Health, Alcohol and Substance Abuse conditions, except as specified.

Covered Physician office services include visits for medical care, consultations and second opinions to: examine, diagnose and treat an illness or injury performed in the Physician's office, including birth control. Office visits also include allergy injections and allergy serum, and allergy testing. Office visits may include administration of injections. If a covered injection requires the use of one of the Specialty Pharmacy Drugs listed on Our Medical Provider Administered Specialty Drug List that Specialty Pharmacy Drug must be received from Our Specialty Pharmacy to be covered. Self-injectable Specialty Drugs administered by a healthcare professional, but are not required to be administered by a healthcare professional in the office setting, must be billed by the Provider through the pharmacy benefit. See the **Specialty Pharmacy** section for more information

**Diagnostic Services** include services that are required to diagnose or monitor a symptom, disease or condition. (Refer to the **DIAGNOSTIC SERVICES** section)

**Surgery** and Surgical services include Anesthesia and supplies. The surgical fee includes normal post-operative care. (Refer to the **SURGICAL SERVICES** section)

**Therapy Services** include services for Physical Medicine Therapies and Other Therapies when rendered in the office of a Physician or other Professional Provider. (Refer to the **THERAPY SERVICES** section)

Such services, even when performed in a Physician's office, will not always be included in, or covered as, an office visit and additional copayment, coinsurance, deductible or benefit restrictions may apply.

### **Inpatient Services**

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Inpatient Services do not include care related to Maternity Services and Mental Health, Alcohol and Substance Abuse conditions, except as specified.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Care Facility (SNF) or other Provider for room expenses, board and general nursing services;
- Ancillary Services; and
- Professional services from a Physician while an Inpatient in an Inpatient setting.

## Skilled Nursing Care Facility (SNF)

When We preauthorize skilled nursing care, benefits are available up to a maximum number of days per Benefit Period as listed on the *Health Benefit Plan Description Form* or until Maximum Medical Improvement is achieved as determined by Us, whichever is earlier. Preauthorization by Us for admission and for continued stay is required. See the **MANAGED CARE FEATURES** heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on Preauthorization guidelines.

### Room, Board and General Nursing Services

- A room with two or more beds;
- A private room, however the allowance is the Provider's average semi-private room rate unless it is Medically Necessary that you occupy a private room for isolation and no isolation facilities are available; and
- A room in a Special Care Unit approved by Us. The Special Care Unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

### Ancillary Services

- Operating, delivery and treatment rooms and equipment;
- Prescribed drugs administered as part of the Inpatient admission;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services;
- Therapy Services; and
- Charges for processing, transportation, handling and administration of blood. Charges for blood, blood plasma and blood products unless received from a community source.

### Professional Services

- Medical care visits limited to one visit per day by any one Professional Provider;
- Intensive medical care for constant attendance and treatment when your condition requires it for a prolonged time;
- Concurrent care for a medical condition by a Professional Provider who is not your surgeon while you are in the Hospital for Surgery: care by two or more Professional Provider during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians;
- Consultation, that is a personal bedside examination by another Professional Provider when requested by your Professional Provider. Staff Consultations required by Hospital rules are excluded;
- Surgery Services, including Reconstructive Surgery;
- Anesthesia, anesthesia supplies and services; and
- Newborn examinations by a Physician other than the Physician who performed the obstetrical delivery.

## Outpatient Services

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Outpatient Services include both Facility and Professional Provider charges when rendered to you as an Outpatient at a Hospital, Alternative Care Facility or other Facility Provider as determined by Us. Outpatient Services do not include care that is related to Maternity Services or Mental Health, Alcohol and Substance Abuse Care, except as otherwise specified. Professional charges only include services billed by a Physician or other Professional Provider.

The services covered for Inpatient Services are also covered for Outpatient Services, except for room, board and general nursing services.

Outpatient Services may include administration of injections. If a covered injection requires the use of one of the Specialty Pharmacy Drugs listed on Our Medical Provider Administered Specialty Drug List that Specialty Pharmacy Drug must be received from Our Specialty Pharmacy to be covered. See the **Specialty Pharmacy** section for more information.

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

For dental services refer to the **DENTAL RELATED SERVICES** section.

## Diagnostic Services

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Coverage for Diagnostic Services when provided as part of Preventive Care Services, Physician Office Services, Infertility Services, Outpatient Services, Home Care Services, Hospice Services, Emergency Care and Urgent Care include the following. See the *Health Benefit Plan Description Form* for benefit limitations:

- X-ray and other radiology services;
- Laboratory and pathology services;
- Cardiographic, encephalographic and radioisotope tests;
- Ultrasound services;
- Allergy tests; and
- Hearing tests, unless related to an examination for prescribing or fitting of a hearing aid, except as required by applicable law.
- Genetic testing when allowed by Anthem's medical policy.
- Ultrafast CT scans when Preauthorized and allowed by Anthem's medical policy.

## Surgical Services

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

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

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Sterilization services;
- Anesthesia and surgical assistance as determined by our medical policy. We do not pay for all surgical assistant procedures. The list of procedures, which allow a surgical assistant or assistant surgeon, is available to your Provider;
- Usual and related pre-operative and post-operative care; and
- Other procedures as approved by Us.

Bariatric surgery and complications from bariatric surgery that satisfy Our medical policy are covered benefits. See the *Health Benefit Plan Description Form* for benefit limitations.

The surgical fee includes normal post-operative care. See the *Health Benefit Plan Description Form* for benefit limitations.

**Note:** If you are receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy and you elect breast reconstruction, you will also receive coverage for:

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

In addition to the above benefits, Covered Services for a mastectomy are also provided under other sections of this Certificate, see the **Physician Office Services, Inpatient Services, Outpatient Services, Therapy Services, and Medical Supplies, Durable Medical Equipment and Appliances** sections.

## Emergency Care and Urgent Care

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

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

### Emergency Care

Emergency Care services, that We determine meet the definition of Emergency Care, will always be covered, whether an In-Network Provider or an Out-of-Network Provider renders the care. For Emergency Care rendered by an Out-of-Network Provider you are not required to pay more than would have been required for services from an In-Network Provider. Emergency care is available twenty-four (24) hours a day, seven (7) days a week. Follow-up care is not considered Emergency Care.

We cover Emergency services necessary to screen and stabilize you without Preauthorization if a prudent person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb-threatening emergency existed. "Life or limb-threatening Emergency" means any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

For Inpatient admissions following Emergency Care, you should contact Us within 24 hours of admission or as soon as reasonably possible to obtain authorization for a specific length of stay. When We are contacted for Authorization, you will be notified of the number of days considered Medically Necessary for your diagnosis.

Care and treatment provided once you are stabilized is not Emergency Care. Continuation of care from an Out-of-Network Provider beyond that needed to screen or Stabilize you in an Emergency will not be covered unless We authorize the continuation of care.

### Urgent Care

Often an urgent rather than an Emergency medical problem exists. Urgent Care can be obtained from an In-Network Provider or an Out-of-Network Provider. If you experience an Accidental Injury or a medical problem, We will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

Urgent Care is care provided for individuals who require immediate medical attention but whose condition is not life-threatening (non-Emergency). Treatment of an Urgent Care medical problem is not an emergency and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and you are advised to go to an emergency room, your care will be paid at the level specified in the *Health Benefit Plan Description Form* for Urgent Care.

### Obtaining Emergency or Urgent Care

If you need Emergency Care or Urgent Care, even while you are away from home, you are covered. Please follow the step-by-step instructions below to help ensure you receive coverage:

- Know the difference between an Emergency and an Urgent Care situation;
- If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. If you are experiencing an Urgent Care medical problem, go to an Urgent Care Center or your Physician's office. If there is not one nearby, then go to the Hospital;
- Call your Physician or Us within 24 hours or as soon as reasonably possible;
- Ask if the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan. More than likely it does;
- If the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, show your Health Benefit Identification (ID) Card to the Hospital staff or Physician. If it does not contract with the local Blue Cross and Blue Shield Plan, you will need to pay the bill and file a claim form with Us;
- If the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, the Hospital or Urgent Care Center will verify your eligibility and get your benefit information from a nationwide electronic data system;
- After you are treated, your claim is sent to Us. You only have to pay the Hospital or Urgent Care Center any cost shares as stated in your *Health Benefit Plan Description Form*; and

- You will receive an Explanation of Benefits form.

#### **Emergency and Urgent Care outside the country:**

- Go to the nearest health care facility;
- Call your Physician or Us within 24 hours or as soon as reasonably possible;
- Once your care is completed, you will need to pay the bill. (You may want to use a credit card. The credit card company will automatically transfer the foreign currency into American dollars for you.) Keep all your receipts;
- When you return home, call Us at the number on the back of your Health Benefit ID Card or stop by your employer's personnel office and ask for a claim form;
- Fill out the claim form and submit it with your receipts to Our address on the form. (The amount submitted must be in American dollars); and
- You will be reimbursed based on the benefits of your Certificate.

### **Ambulance and Transportation Services**

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate except as provided below.

Covered Ambulance and transportation services are by a vehicle designed, equipped and used only to transport the sick and injured:

- From your home, scene of accident or medical Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and a Skilled Nursing Care Facility; or
- From a Hospital or Skilled Nursing Care Facility to your home.

Ground Ambulance is usually Our approved method of transportation. Air Ambulance is only a benefit when terrain, distance or your physical condition requires the services of an air Ambulance. We will determine whether transport by air Ambulance is a benefit on a case-by-case basis. If we determine that air Ambulance was used when ground Ambulance could have been used, benefits will be limited to ground Ambulance benefits.

Ambulance services are a Covered Service only when Medically Necessary for Emergency care. Ambulance services may also be a Covered Service:

- When ordered by an employer, school, fire or public safety official and you are not in a position to refuse; or
- When you are requested by Us to move from an Out-of-Network Provider to an In-Network Provider.

Trips must be to the closest local facility that can provide Covered Services appropriate for your condition. If a local facility is not available, you are covered for trips to the closest such facility outside your local area.

If you elect not to receive transport to a facility after an Ambulance has been called, your, Deductible and/or Coinsurance will still apply.

### **Therapy Services**

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Coverage for Therapy Services when provided as part of Provider Office Services, Inpatient Services, Outpatient Services or Home Care Services is limited to the following:

#### **Physical, Occupational and Speech Therapy**

From the Member's birth until the members sixth (6th) birthday, benefits are allowed up to the maximum visits listed on the *Health Benefit Plan Description Form*, or 20 visits each, whichever is greater, per Benefit Period for physical, speech and occupational therapies. Benefits are for the care and treatment of congenital defects and birth abnormalities for covered children without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy it to maintain or improve functional capacity. From the Members birth until the Member's third (3rd) birthday, these early intervention services shall be provided only where and only to the extent required by applicable law.

For all other Member's (e.g. those six (6) and older, or who not qualify for the benefits above), benefits are provided only if the physical, speech or occupational therapy will result in a practical improvement in the level of functioning within a reasonable period of time and the physical, speech or occupational therapy must be medically necessary. Benefits physical, speech or occupational are allowed up to the maximum visits as listed on the *Health Benefit Plan Description Form*.

- **Physical Therapy** including treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function and to prevent disability following illness, injury or loss of a body part, or as a result of a Congenital Defect or Birth Abnormality.
- **Speech Therapy** for the correction of a speech impairment resulting from illness, injury, surgery or as a result of a Congenital Defect or Birth Abnormality as determined by Anthem's medical policy.
  - **Cleft Palate or Cleft Lip.** For a cleft palate or cleft lip condition, Speech Therapy benefits are unlimited, as long as Medical Necessity has been demonstrated. Such Speech Therapy visits reduce the maximum visits but are not limited to the maximum visits. Additional services for cleft plate or cleft lip can be found under the **DENTAL RELATED SERVICES** section.
- **Occupational Therapy** for the treatment of a person with physical disabilities or as a result of Congenital Defect or Birth Abnormality by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. It also includes tasks required by the person's particular occupational role.

#### **Other Therapy Services**

- **Chiropractic benefits** are allowed for services administered by a chiropractor or acupuncturist who acts within the scope of licensing for the chiropractic treatment of an illness or accidental injury. Chiropractic benefits are limited to the office visits with manual manipulation of the spine, X-ray of the spine and certain physical modalities and procedures. Acupuncture benefits are limited to the office visit for the treatment of an illness or injury. All benefits are limited to a combined maximum of 12 office visits per members benefit year for all care. If a member visits a chiropractor and/or acupuncturist more than once in a single day, each such visit will be counted as one visit. See your *Health Benefit Plan Description Form* for the maximum number of visits per Benefit Period.
- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. Benefits are allowed at a facility for exercise and education under the direct supervision of skilled program personnel in an intensive outpatient rehabilitation program. From 6 to 36 visits are allowed based on Our Medical Policy, and the program must start within three months of the major cardiac event and be completed within six months of the major cardiac event.
- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents. Chemotherapy services are available through the Providers office. Chemotherapy medications used in conjunction with outpatient therapy may be considered Specialty Pharmacy Drugs when such medication is listed on Our Medical Provider Administered Specialty Drug List and they must be received from Our Specialty Pharmacy. See the **Specialty Pharmacy** section for more information.
- **Dialysis** treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- **Radiation Therapy** for the treatment of disease by x-ray, radium or radioactive isotopes.
- **Inhalation Therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

### **Physical Medicine and Rehabilitation Services**

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Covered Services are Inpatient Services for Physical Medical and Rehabilitation services through a structured therapeutic program of an intensity that requires a multi-disciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible. This includes skilled rehabilitative nursing care, Physical Therapy, Occupational Therapy, Speech Therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

The variety and intensity of treatments required is the major differentiation from an admission primarily for Physical Therapy. See your *Health Benefit Plan Description Form* for benefit limitations.

## Home Care/Home IV Therapy Services

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Services performed by a Home Health Agency or other Provider in your residence. The services must be provided on a part-time visiting basis according to a course of treatment. Refer to your *Health Benefit Plan Description Form* for benefit limitations. Covered Services include the following:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.);
- Medical/social services;
- Diagnostic Services;
- Nutritional guidance;
- Certified Nurse Aide services under the supervision of an R.N. or a therapist qualified with professional nursing services;
- Therapy Services (not subject to the therapy limits listed on the *Health Benefit Plan Description Form* when provided by a Home Care Agency);
- Medical and Surgical Supplies;
- Durable Medical Equipment;
- Prescription Drugs (only if provided and billed by a Home Health Care Agency); and
- Specialty Pharmacy Drugs listed on Our Medical Provider Administered Specialty Drug List must be obtained through Our Anthem's Specialty Pharmacy. See the **Specialty Pharmacy** section for more information.

### Home IV Therapy

Home IV therapy is covered and includes a combination of nursing, Durable Medical Equipment and IV pharmaceutical services that are delivered and/or administered intravenously in the home. Home IV Therapy includes services and supplies such as for Total Parenteral Nutrition (TPN), Antibiotic therapy, pain management and Chemotherapy. TPN received in the home is a covered benefit for the first 21 days following a Hospital discharge when it is determined to be Medically Necessary. Additional days may be allowed up to a maximum of 42 days per Benefit Year when preauthorized by Us.

Home IV services are covered only if received from a home infusion Provider which is an In-Network Provider.

### Medical Foods

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Benefits are provided for medical foods for home use for metabolic disorders which may be taken orally or enterally. A Provider must have prescribed the medical foods that are designed and manufactured for inherited enzymatic disorders involved in the metabolism of amino, organic, and fatty acids. Such disorders include phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia and propionic acidemia. The maximum age to receive benefits for phenylketonuria is 21 years of age; except the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is 35 years of age. This benefit does not include enteral nutrition therapy or medical foods for Members with cystic fibrosis or lactose- or soy- intolerance.

All covered medical foods must be obtained through an In-Network Pharmacy and are subject to the Pharmacy Copayment.

### Hospice Care

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

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

Hospice Services include:

- Hospice day care;
- Home Care services;
- Skilled nursing services (by an R.N. or L.P.N.);
- Social/counseling services;
- Physician services;
- Physical, Occupational, Speech and Respiratory Therapies;
- Nutritional counseling by a nutritionist or dietitian;
- Medical Supplies (including respiratory supplies), Durable Medical Equipment (rental or purchase), oxygen, appliances, prostheses and Orthopedic Appliances;
- Counseling services for the covered Member;
- Bereavement support services for the covered family Members;
- Inpatient Hospice respite care. Inpatient Hospice respite care may be provided only on an intermittent, nonroutine, short-term basis;
- Intravenous medications and other prescription drugs ordinarily not available through a Retail Pharmacy;
- Short-term inpatient (acute) Hospice Care or continuous home care which may be required during a period of crisis, for pain control or symptom management;
- Diagnostic testing; and
- Transportation.

## Human Organ and Tissue Transplant Services

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

For cornea and kidney transplants, the transplant or tissue benefits or requirements described below do not apply. Those services are paid as Inpatient Services, Outpatient Services, or Physician Office Services depending on where the service is performed. Coverage for Human Organ and Tissue Transplants are covered when provided as part of Physician Office Services, Inpatient Services, and Outpatient Services.

We shall provide benefits for Human Organ and Tissue Transplant services only when We have Preauthorized the services. We must designate and approve the Hospital who is performing the specific Covered Services provided under this benefit. Please note, not every designated Hospital performs each of the specified Covered Services.

We and the approved Hospital must determine if you are a candidate for any of the Covered Services specified in this section.

Covered transplant services are defined as any of the following Human Organ and Tissue Transplants or procedures:

- Heart;
- Lung (single or double);
- Heart-Lung;
- Kidney-Pancreas;
- Pancreas;
- Liver;
- Peripheral Stem Cell (i.e. bone marrow); and
- Small bowel.

We may amend the above covered transplant services list to include additional organ or tissue transplants.

If you are now eligible, or anticipate receiving eligibility for Medicare benefits, you are solely responsible for contacting Medicare to determine if the transplant will be eligible for Medicare benefits.

### **Other services**

- Immunosuppressant drugs prescribed for Outpatient use in connection with a covered Human Organ and Tissue Transplant that are dispensed only by written prescription and that are approved for general use by the Food and Drug Administration, but only if your coverage has a Prescription Drug benefit.
- Transportation costs incurred for travel to and from the site of Surgery for Covered Services. Transportation will be for you (the transplant recipient) and one other individual to accompany you, or, if the transplant recipient is a minor child, transportation costs for two other individuals to accompany the transplant recipient.
- Benefits for transportation and lodging for the transplant recipient and companion(s) is limited to a maximum payment of \$10,000 per transplant, not to exceed a specific total per day for reasonable and necessary lodging and meal expenses.
  - You are responsible for monitoring the accumulation of expenses and for submitting documentation of travel expenses. No benefits will be paid until after the transplant services are received. Coverage is not available for travel costs associated with a pretransplant evaluation if the travel occurs more than one (1) day before the actual transplant.
- Transportation of the donor organ or tissue.
- Evaluation and surgical removal of the donor organ or tissue and related supplies.

As used in this section, the term donor means a person who furnishes organ tissue for transplantation. If a Human Organ or Tissue Transplant is provided from a donor to a transplant recipient, the following apply:

- When both the recipient and the donor are Our Members, each is entitled to the Covered Services specified in this section.
- When only the recipient is a Member, both the donor and the recipient are entitled to the Covered Services specified in this section.
- The donor benefits are limited to those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, grants, foundations, government programs, etc.
- If the donor is Our Member, and the recipient is not covered by Us, benefits will not be provided for the donor or recipient expenses.

Covered Services related to the donor and/or donated organ or tissue, such as Hospital, surgical, medical, storage and transportation costs are subject to a maximum payment of \$25,000 per transplant. Benefits provided to the donor will be charged against the recipient Member's coverage and will apply toward the Member's Lifetime Maximum for Human Organ and Tissue Transplants.

No benefits will be provided for procurement of a donor organ or organ tissue that is not used in a covered Transplant procedure, unless the transplant is cancelled due to the Member's medical condition or death and the organ cannot be transplanted to another person.

The benefits for all Covered Services specified in this section for Human Organs and Tissue Transplants are limited to a Lifetime Maximum payment of \$1,000,000 per covered Human Organ and Tissue Transplant. This includes all Covered Service maximums specified in this section. If you receive a covered Human Organ and tissue Transplant e.g., heart transplant, and later require another transplant of the same type e.g. (another heart transplant), the covered benefits for the new transplant are limited to the remaining (if any) Lifetime Maximum benefits available for the transplant under this Certificate or any successive Certificate with Us.

Only those Human Organ and Tissue Transplants and directly related procedures specified in this section are Covered Services under this benefit. Benefits will only be provided for Covered Services and supplies furnished to the transplant recipient during the period beginning five (5) days before the covered Human Organ and Tissue Transplant procedure and ending three hundred sixty-five (365) days after the covered transplant procedure is performed.

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

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

The supplies, equipment and appliances described below are covered under this benefit. If the Medical Supply, equipment and/or appliances includes comfort, luxury or convenience items, the amount of benefits allowed is based on the Maximum Benefit Allowance for the eligible standard item. Any expense that exceeds the Maximum Benefit Allowance for the standard item is your responsibility.

Benefits in this section are allowed up to a Benefit Period Maximum. See the *Health Benefit Plan Description Form* for benefit limitation.

### **Medical and Surgical Supplies**

Syringes, needles, oxygen, surgical dressings, splints and other similar items that serve only a medical purpose, including diabetic supplies.

### **Durable Medical Equipment**

The rental (or, at Our option, the purchase) of Durable Medical Equipment prescribed by a Physician or other Provider. Rental costs must not be more than the purchase price. This equipment must serve only a medical purpose and be able to withstand repeated use. Repair of medical equipment is covered.

### **Prosthetic Devices**

Purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

- Replace all or part of a missing body part and its adjoining tissues; or
- Replace all or part of the function of a permanently ineffective or malfunctioning body part.

For prosthetic arms and legs the allowance is as provided for under federal law for health insurance for the aged and disabled. Prosthetic arms and legs are not subject to the Benefit Period Maximum

Benefits for prosthetic devices include:

- Either one set of standard prescription eyeglasses or one set of contact lenses (whichever is appropriate for the medical condition) when necessary to replace human lenses absent at birth or lost through intraocular Surgery, ocular injury or for the treatment of keratoconus or aphakia;
- Breast prostheses and two surgical brassieres each Benefit Period following a mastectomy; and
- The first wig following cancer treatment.

### **Orthopedic Appliances**

Purchase, fitting, needed adjustment, repairs, and replacements of Orthopedic Appliances and supplies that are rigid or semi-rigid supportive device and that limit or stop motion of a weak or diseased body part.

Non-covered items include but are not limited to Orthotics and orthopedic shoes (except if you are diagnosed with diabetes).

## **Hearing Aid Services**

The following hearing aid services are covered up to your eighteenth (18th) birthday when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist:

- Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be provided as part of the **DIAGNOSTIC SERVICES** section.
- Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment. Initial and replacement hearing aids will be supplied every 5 years, or when alterations to the existing hearing aid cannot adequately meet your needs.
- Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

## **Dental Related Services**

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

### **Accident-Related Dental Services**

Benefits are provided for accident-related dental expenses when the Member meets all of the following criteria:

- Dental services, supplies and appliances are needed because of an accident in which the Member sustained other significant bodily injuries outside the mouth or oral cavity. Treatment must be for injuries to your sound natural teeth.
- Treatment must be necessary to restore your teeth to the condition they were in immediately before the accident.
- The first dental services must be performed within 90 days after your accident.
- Related services must be performed within one year after your accident. Services after one year are not covered even if coverage is still in effect.

Benefits for restorations are limited to those services, supplies, and appliances Anthem determines to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident.

### **Dental Anesthesia**

Benefits are provided for general Anesthesia when provided in a Hospital, outpatient surgical facility or other facility, and for associated Hospital or facility charges for dental care for a Covered Dependent Child who 1) has a physical, mental or medically compromising condition; 2) has dental needs for which local Anesthesia is not effective because of acute infection, anatomic variation or allergy; 3) is extremely uncooperative, unmanageable, uncommunicative or anxious and whose dental needs are deemed sufficiently important that dental care cannot be deferred; or 4) has sustained extensive orofacial and dental trauma.

### **Cleft Palate and Cleft Lip Conditions**

Benefits are allowed for Inpatient care and Outpatient care, including orofacial Surgery, surgical management and follow-up care by plastic surgeons and oral surgeons, orthodontics, prosthetic treatment such as obturators, speech appliances, and prosthodontic and surgical reconstruction for the treatment of Cleft Palate and/or Cleft Lip. If you have a dental policy, the dental policy would be the primary policy and must fully cover orthodontics and dental care for Cleft Palate and/or Cleft Lip conditions.

The only other dental expenses that are Covered Services are facility charges for Inpatient and/or Outpatient Services. Benefits are payable only if the Member's medical condition or the dental procedure requires an appropriate setting to ensure the safety of the Member.

## **Mental Health, Alcohol and Substance Abuse Care Services**

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Inpatient Services, Outpatient Services and Physician Office Services for the treatment of Mental Health Conditions, Alcohol Dependency or Substance Dependency are covered for the diagnosis, crisis intervention and short-term treatment of Mental Health Conditions and for rehabilitation of Alcohol Dependency or Substance Dependency. Admissions solely for detoxification for Alcohol Dependency or Substance Dependency, which do not include rehabilitation, are limited to three (3) per Members Benefit Period. Benefits are limited as specified in the *Health Benefit Plan Description Form*.

Services for Mental Health Conditions which are not listed below will be paid only if you obtain prior approval from Our Mental Health Subcontractor and receive services from the Provider designated by that Preauthorization.

Biologically Based Mental Illness conditions, detoxification for Alcohol Dependency and Substance Dependency, autism, other mental disorders of posttraumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder, anorexia nervosa and bulimia nervosa (to the extent anorexia nervosa and bulimia nervosa are treated on an Out-Patient, day treatment and In-Patient basis, excluding residential treatment) are covered under your medical benefits and are not subject to the limitations of the Mental Health, Alcohol and Substance Abuse Care benefits.

Benefits are provided for medication management for Mental Health Care conditions provided by your medical Provider, psychiatrist or prescriptive nurse. If the medication management is provided by your Medical Provider, benefits are paid under your medical benefit. If medication management is provided by a psychiatrist or a prescriptive nurse, benefits are paid under your mental health benefit. For coverage of prescription drugs, see the **PRESCRIPTION DRUG** section (when applicable).

**Inpatient Services.** Inpatient Services to treat Mental Health Conditions, Alcohol or Substance abuse include:

- Individual psychotherapy;
- Group psychotherapy;
- Psychological testing;
- Family counseling with family Members to assist in your diagnosis and treatment; and
- Convulsive therapy including electroshock treatment and convulsive drug therapy.

**Partial Hospitalization Services.** The services covered for Inpatient Services for Mental Health, Alcohol and Substance abuse are also covered for partial hospitalization. Partial hospitalization may be substituted for Inpatient benefits at two (2) days for each available Inpatient day. Partial hospitalization means continuous treatment for at least three (3) hours but no more than twelve (12) hours in any twenty-four (24) hour period.

**Outpatient Services.** The services covered for Inpatient Mental Health Care, Alcohol and Substance abuse services are also covered for Outpatient services, except room, board and general nursing services, and include intensive outpatient treatment.

## Retail Pharmacy/Mail Order Prescription Drugs

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

This section describes Our outpatient pharmacy benefits for medications obtained through an In-Network Retail Pharmacy or Mail-Service Pharmacy. You must obtain covered Prescription Drugs and supplies from an In-Network pharmacy. All Prescription Drugs must be on Our Prescription Drug list to be eligible for benefits.

Outpatient Pharmacy services do not include services received in the Hospital as an Inpatient, if a Medical Supply, durable medical equipment or appliance or when provide by a Specialty Pharmacy. Refer to the **INPATIENT SERVICES**, and **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT AND APPLIANCES** sections for services covered by the Certificate. For medications or equipment not obtained through a pharmacy, see the **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES** section of this Certificate. Specialty Pharmacy Drugs listed on Our Self-Administered Specialty Drug List must be obtained through Our Specialty Pharmacy. See the **SPECIALTY PHARMACY** section for more information.

The Outpatient pharmacy benefits available under this Certificate are managed by Our pharmacy benefit management company affiliate, which is a pharmacy benefits management company. As part of its services to Us, the pharmacy affiliate offers a nationwide network of Retail Pharmacies, a Mail-Service Pharmacy, a Specialty Pharmacy and clinical services.

You may review the current formulary Prescription Drug list on Our website at [www.anthem.com](http://www.anthem.com), under "Search the Drug List". You may also request a copy of the Formulary/drug list by calling our customer service department. The Formulary/drug list is subject to periodic review and amendment. Inclusion of a drug or related item on the Formulary/Prescription Drug list is not a guarantee of coverage.

For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before We will determine Medical Necessity. We may, at Our sole discretion, establish quantity limits for specific Prescription Drugs. The pharmacy affiliate, in consultation with Us also promotes and enforces the appropriate use of medications by reviewing for improper dosage, potential drug to drug interactions or drug-disease state interactions. Your Copayment amount depends on whether the drug you receive is a first, second or third tier drug. See the *Health Benefit Plan Description Form* to determine the associated Copayment for each tier.

The amount of benefits paid is based upon whether you obtain covered drugs and supplies from a In-Network pharmacy or Mail Service Pharmacy. A Prescription Drug must be a Legend Drug to be eligible for benefits.

We have established a National Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs, determining the tier assignments of drugs, and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determination of tiers is made by Us based on clinical decisions provided by the National P&T Committee, and where appropriate the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives and where appropriate, certain clinical economic factors.

We retain the right at Our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical, or inhaled) and may cover one form of administration and exclude or place other forms of administration on another tier.

Your Copayment amount is based upon the above and which tier the Prescription Drug falls under as follows:

**Tier-1** - means a drug that has the lowest Copayment. This tier will contain low cost or preferred medications. This tier may include Generic drugs, Single Source drugs and Multi-Source Brand drugs.

**Tier-2** - means a drug that has a higher Copayment than those in tier 1. This tier will contain preferred medications that generally are moderate in cost. This tier may include Generic drugs, Single Source Brand drugs and Multi-Source drugs.

**Tier-3** - means a drug that has a higher Copayment than those on tier 2. This tier may contain non-preferred medications which are generally higher in cost. This tier may include Generic drugs, Single Source Brand drugs, and Multi-Source Brand drugs.

Certain Prescription Drugs (or the prescribed quantity of a particular drug) may require Preauthorization. At the time you fill a prescription, the In-Network pharmacist is informed of the Preauthorization requirement through the pharmacy's computer system, and the pharmacist is instructed to contact Our pharmacy affiliate. For a list of current drugs requiring Preauthorization, contact Our customer service department, or review the list on Our website at [www.anthem.com](http://www.anthem.com).

The Provider or In-Network pharmacist can check with Us to verify drug tier placement, any quantity limits, Step-Therapy, Preauthorization requirements, or appropriate Brand or Generic drugs recognized under the Certificate.

From time to time We may initiate various voluntary programs to encourage you to utilize more cost-effective or clinically-effective drugs including but not limited to, Generic drugs, mail-order drugs, over-the counter, or preferred products. Such programs may involve reducing or waiving Copayments for certain drugs or preferred products for a limited period of time. We may discontinue a program at any time. If you are participating in a program that We are discontinuing We will provide you at least a 30 day advance written notice of the discontinuance.

Outpatient pharmacy benefits received from a In-Network pharmacy are limited to:

- Prescription Drugs, including self-administered injectable drugs;
- Injectable insulin and syringes used for administration of insulin;
- Oral contraceptive drugs and contraceptive devices;
- Certain supplies, equipment and appliances (such as those for diabetes and asthma). You may contact Us to determine supplies covered through a pharmacy; and
- Smoking cessation Prescription Drugs up to the lifetime maximum payment as indicated on the *Health Benefit Plan Description Form*.

Each prescription is subject to a Copayment. If the prescription order includes more than one covered drug or supply, a separate Copayment is required for each covered drug or supply. The Copayment will be the lesser of your Copayment, or the allowed amount charged for the prescription by the pharmacy or mail order service that fills the prescription. The Copayment will not be reduced by any discounts, rebates or other funds received by Our pharmacy affiliate from drug manufactures, or similar vendors and/or funds received by Us from Our pharmacy affiliate. We will make no payment for any covered drug or supply unless Our negotiated rate exceeds any applicable Copayment for which you are responsible.

You are limited a 30-day supply of a prescription drug if obtained at an In-Network pharmacy or up to a 90-day supply if received through mail order. When Medically Necessary, a vacation override is available with applicable Copayment if you are traveling out of Our Service Area.

The Half-Tablet Program will allow you to pay a reduced Copayment on selected “once daily dosage” medications. The Half-Tablet Program allows you to obtain a 30-day supply (15 tablets) of the higher strength medication when written by a Physician to take “1/2 tablet daily” of those medications on the approved list. The National P&T Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and your decision to participate should follow consultation with and the concurrence of your Physician. This program is only available through a Retail Pharmacy or Mail Services Pharmacy. To obtain a list of the products available on this program contact Customer Service.

You may need to file your own claim if you need to have a prescription filled before you receive your Health Benefit ID card. The In-Network Pharmacy cannot submit the claim on your behalf.

We receive financial credits or rebates from drug manufacturers based on the total volume of claims processed for their products utilized by Our Members. These credits are used to help stabilize rates. Reimbursements to pharmacies are not affected by these credits.

### **Mail Service Program**

You may also purchase your maintenance medication by utilizing Our In-Network Mail Service Pharmacy and have your prescription delivered directly to your home. To receive your maintenance medicine prescription by mail, follow these 3 steps:

- Ask your doctor to prescribe a 90-day supply of your maintenance medicine plus three refills (certain medications may be subject to state or federal dispensing limitations). If you need the medicine immediately, ask your doctor for two prescriptions, one to be filled right away at a retail pharmacy and another to be sent to the Mail Service pharmacy;
- Complete the order form which is enclosed within the Mail Service Pharmacy envelope; and
- Mail your questionnaire, written prescription(s), and a check to cover the amount of your Copayment(s) to the Mail Service Pharmacy. Credit card, debit card or checks are acceptable.

You will receive your Prescription Drugs via first class mail or UPS approximately 14 days from the date you sent your order. Orders can be tracked on Our website via MyHealth at [www.anthem.com](http://www.anthem.com).

**Helpful Tip:** We suggest that you order your refill two weeks before you need it to avoid running out of your medication. Any questions concerning the Mail Service Pharmacy program, contact customer service department.

You will receive refill forms and a notice that shows the number of refills your doctor ordered in the package with your drugs. To order refills, you must have used 75% of your mail order prescription. You may use Our website at [anthem.com](http://anthem.com) under MyHealth at [Anthem.com](http://Anthem.com) or contact Our customer service department to obtain the mailing address for Our Mail Service Pharmacy.

## Specialty Pharmacy

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Certificate.

Certain Specialty Pharmacy Drugs obtained from a medical Provider or a Retail Pharmacy must be ordered through Our Specialty Pharmacy by you or your Provider. The benefits of this section include services on Our Medical Provider Administered Specialty Drug List and Self-Administered Specialty Drug List for Specialty Pharmacy Drugs. Specialty Pharmacy Drugs are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at a Retail Pharmacy or through a Mail Service Pharmacy. Benefits are only provided when you receive services from a Specialty Pharmacy as determined by Us for those Specialty Pharmacy Drugs included on Our Medical Provider Administered Specialty Drug List and Self-Administered Specialty Drug List.

Specialty Pharmacy services are for Specialty Pharmacy Drugs and do not include services received from a Retail Pharmacy, in the Hospital as an Inpatient, if a Medical Supply, durable medical equipment or appliance. Refer to the **INPATIENT SERVICES** and **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES** sections for services covered by the Certificate. This section describes our outpatient pharmacy benefits for Specialty Pharmacy Drugs obtained through a Specialty Pharmacy which will be used in place of receiving the service from your Physician's office, Retail Pharmacy or other specialty pharmacy unless you qualify for an exception.

The Outpatient Specialty Pharmacy benefits available under this certificate are provided by Our Specialty Pharmacy affiliate. As part of its services to Us, the Specialty Pharmacy affiliate is a full service Specialty Pharmacy which ships medications to you by overnight mail or common carrier for up to a 30-day supply (you cannot pick up your medication from the Specialty Pharmacy affiliate). Our Specialty Pharmacy Management affiliate is not a Retail Pharmacy or a Mail Service Pharmacy.

We have established a National Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs, determining the tier assignments of drugs, and advising on programs to help improve care. Such programs may include, but are not limited to, drugs utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drugs profiling initiatives and the like.

The determination of tiers is made by Us based on clinical decisions provided by the National P&T Committee, and where appropriate the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives and where appropriate, certain clinical economic factors.

We retain the right at Our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical, or inhaled) and may cover one form of administration and exclude or place other forms of administration on another tier.

You may review the current Medical Provider Administered Specialty Drug List and Self-Administered Specialty Drug List on Our website at [www.anthem.com](http://www.anthem.com). You may also request a copy of either list by calling our customer service department. Our Medical Provider Administered Specialty Drug List and Self-Administered Specialty Drug List are subject to periodic review and amendment. Inclusion of a drug or related item on either list is not a guarantee of coverage.

Your Copayment amount is based upon the above and which tier the Specialty Pharmacy Drug fall under as follows:

**Tier-1** - means a drug that has the lowest Copayment. This tier will contain low cost or preferred medications. This tier may include Generic drugs, Single Source drugs and Multi-Source Brand drugs.

**Tier-2** - means a drug that has a higher Copayment than those in tier 1. This tier will contain preferred medications that generally are moderate in cost. This tier may include Generic drugs, Single Source Brand drugs and Multi-Source Brand drugs.

**Tier-3** - means a drug that has a higher Copayment than those on tier 2. This tier may contain non-preferred medications which are generally higher in cost. This tier may include Generic drugs, Single Source Brand drugs, and Multi-Source Brand drugs.

Prescription Drugs will always be dispensed as ordered by your Provider and by applicable State Pharmacy Regulations. You may request, or your Provider may order, a Brand-Name drug. However, if a Generic drug is available, you will be responsible for the cost difference between the Generic and Brand-Name drug, in addition to your tier 1 Copayment. By law, Generic and Brand-Name drugs must meet the same standards for safety, strength, and effectiveness. Using Generics generally saves money, yet provides the same quality. We reserve the right, at our discretion, to remove certain higher cost Generic drugs from this policy.

We use a variety of administrative processes and tools, such as Preauthorization for health care services to help determine the most appropriate use and cost-effective compared to alternative interventions for the health care services available to Our Members. Certain Specialty Pharmacy Drugs may require Preauthorization. At the time you fill a prescription, you will be informed of the Preauthorization requirement. For a list of current drugs requiring Preauthorization, contact Our customer service department, or review the list on Our website at [www.anthem.com](http://www.anthem.com). You can also check with Us to verify drug tier placement or Preauthorization requirements.

From time to time We may initiate various voluntary programs to encourage you to utilize more cost-effective or clinically-effective drugs including but not limited to, generic drugs, mail-order drugs, over-the counter, or preferred products. Such programs may involve reducing or waiving Copayment for certain drugs or preferred products for a limited period of time. We may discontinue a program at any time. If you are participating in a program that We are discontinuing We will provide you at least a 30 day advance written notice of the discontinuance.

You or your Physician may order your Specialty Pharmacy Drug from Our Specialty Pharmacy Management affiliate by calling 1-800-870-6419. A dedicated care coordinator will guide you or your Physician through the process up to and including actual delivery of your Specialty Pharmacy Drug to you or your Physician. When you order a Specialty Pharmacy Drug for home or physician office use, you will need to pay the appropriate Copayment for each Specialty Pharmacy Drug by check, money order, credit card or debit card and provide all necessary information. For subsequent refills you will be contacted by your care coordinator.

You may also contact Our Specialty Pharmacy Management affiliate at:

2825 W. Perimeter Road, Suite 116  
Indianapolis, IN 46241  
Fax 1-800-824-2642

### **Exception Process for Specialty Pharmacy Drugs**

If you or your Provider believe that you should not be required to get your Specialty Pharmacy Drugs from a Specialty Pharmacy, you must follow the exception process which is available from Our customer service department or at [www.anthem.com](http://www.anthem.com).

## GENERAL EXCLUSIONS

This section indicates services, supplies, conditions, situations and charges that are excluded from coverage and are not considered Covered Services under this Certificate. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. The exclusions below are in addition to the exclusions found elsewhere in this Certificate, including but not limited to those exclusions found in the **COVERED SERVICES** section of this Certificate. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services.

### **We do not provide benefits for services, supplies, conditions, situations or charges:**

1. That We determine are not Medically Necessary Emergency medical care is not subject to this exclusion as long as such care meets the definition of emergency medical care, see the **Emergency Care and Urgent Care** section of this Certificate;
2. Received from an individual or entity that is not a Provider, as defined in this Certificate;
3. That are Experimental/Investigational or related to such, whether incurred before, in connection with, or subsequent to the Experimental/Investigational service or supply, as determined by Us;
4. To the extent they are available as benefits through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits under this Certificate will be coordinated with such governmental units to the extent required under existing state and/or federal laws;
5. For which benefits are payable under Medicare Part A and/or Part B, unless otherwise specified in this Certificate or as otherwise prohibited by federal law, as addressed in the section titled **Medicare** in **ADMINISTRATIVE INFORMATION**;
6. In excess of the Maximum Benefit Allowance for Medical Supplies, durable medical equipment and appliances unless otherwise specified in this Certificate;
7. Incurred before your Effective Date;
8. Incurred after the termination date of this coverage unless otherwise specified in this Certificate;
9. For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Cosmetic Services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for Surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, or chest), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies or previous therapeutic process or pursuant to breast reconstruction following a mastectomy. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Certificate. Other reconstructive services are not covered except as otherwise required by law;
10. For services performed to maintain or preserve the present level of function or prevent regression of function for an illness, injury or condition that is resolved or stable;
11. For dental prosthesis and any treatment for teeth, gums, tooth or upper or lower jaw augmentation or reduction (orthognathic Surgery) and related service, unless otherwise specified in this Certificate;
12. Related to weight loss unless part of a Disease Management program offered by Us;
13. Treatment of obesity, except for surgical treatment of morbid obesity (bariatric surgery) up to the maximum benefit as listed on the *Health Benefit Plan Description Form*;
14. For care received in an emergency room which is not Emergency Care;
15. For research studies or screening examinations, unless otherwise specified in this Certificate;
16. For stand-by charges of a Physician;
17. Immunizations for travel;
18. Routine exams and immunizations required as a condition of employment, for licensing, sport programs, insurance, church, or camp;

19. For Private Duty Nursing Services, except when provided through the Home Care Services or Hospice Care Services sections of this Certificate;
20. Related to male or female sexual or erectile dysfunction or inadequacies, regardless of origin or cause. This exclusion includes Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency;
21. For food services, meals, formulas and supplements, enteral formulas other than those listed in this Certificate as a Covered Service or resulting from dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition;
22. For complications arising from non-Covered Services and supplies;
23. Related to your leaving a Hospital or other facility against the medical advice of the Physician;
24. For services or supplies for the treatment of Intractable Pain and/or Chronic Pain;
25. Services that exceed the visit or Benefit Period Maximum payments as listed in the Certificate or *Health Benefit Plan Description Form* even if you have satisfied the Out-of-Pocket Annual Maximum;
26. For any Pre-Existing Condition during the waiting period as described in the **MEMBERSHIP** section;
27. For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party, except as specified under the **ADMINISTRATIVE INFORMATION** section;
28. For any illness or injury that occurs as a result of any act of war, declared or undeclared, while serving in the military, or services and supplies furnished by a military facility for disabilities connected to military service;
29. For a condition resulting from a riot, civil disobedience, nuclear explosion or nuclear accident;
30. For court-ordered testing or care unless Medically Necessary and preauthorized by Us;
31. For which you have no legal obligation to pay in the absence of this or like coverage;
32. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
33. Prescribed, ordered or referred by, or received from, a member of your immediate family (parent, child, Spouse, sister, brother or self);
34. For completion of claim forms or charges for medical records or reports, unless otherwise required by law;
35. For missed or canceled appointments;
36. For mileage costs or other travel expenses, except as preauthorized by Us;
37. For Custodial Care, or domiciliary or convalescent care, whether or not recommended or performed by a professional;
38. For foot care to improve comfort or appearance including, but not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails;
39. For sex transformation Surgery and related services, or the reversal thereof;
40. For marital counseling or personal growth;
41. For eyeglasses, contact lenses or their fitting, vision therapy or routine vision exams, unless otherwise specified in this Certificate;
42. For hearing aids services, unless otherwise specified in this Certificate;
43. For services or supplies primarily for educational, vocational, or training purposes, unless otherwise specified in this Certificate;
44. For reversal of sterilization;

45. Services of any type for the treatment of infertility;
46. For Experimental infertility procedures and non-Medically Necessary infertility procedures including, but not limited to artificial insemination, In-Vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT);
47. For or related to services (including but not limited to speech therapy) for dysfunctions that are self-correcting such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting, learning disabilities, behavioral problems, hyperkinetic syndromes or mental retardation (except for Prescription Drugs for treatment of these conditions if Prescription Drugs are a covered benefit);
48. For personal hygiene services, self help devices that are not medical in nature, or services and supplies for comfort and convenience;
49. For care related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy;
50. Received at a health spa or similar facility, or for home exercise or therapy equipment;
51. For self-help training and other forms of non-medical self care, unless otherwise specified in this Certificate;
52. For hair loss treatment, even if the hair loss is caused by a medical condition, except for alopecia areata or as otherwise specified in this Certificate;
53. For peripheral bone density scans;
54. For storage or other administrative costs, except when provided as part of the Inpatient Services and Human Organ and Tissue Transplant Services;
55. For medical, surgical services and appliances related to temporomandibular joint (TMJ) therapy regardless of Medical Necessity;
56. For the cost of donor sperm or donor eggs, storage costs for sperm or frozen embryos, or diagnostic tests to determine the effectiveness of a procedure designed to promote fertility or pregnancy;
57. Provided or billed by a residential treatment center, school, halfway house, custodial care facility for the developmentally disabled, drug and alcohol residential program , or outward bound program, even if psychotherapy is included;
58. For rolfing therapy, myotherapy or prolotherapy;
59. For ambulance transportation if you could have been transported by private automobile or by commercial or public transportation without endangering your health or safety;
60. For orthotics, orthopedic shoes and arch supports (except if you are diagnosed with diabetes);
61. For air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, wristlets, breast pumps, augmentative communication devices, surgical supports, and corsets or other articles of clothing, unless otherwise specified in this Certificate;
62. For items usually stocked in the home for general use like Band-Aids, thermometers and petroleum jelly;
63. Sclerotherapy for the treatment of varicose veins in the lower extremities, including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy. Treatment of telangiectatic dermal veins (spider veins) by any method.
64. Services received from Out-of-Network Providers for the following services: Substance Abuse care, Durable Medical Equipment and Supplies (including oxygen and diabetic supplies and equipment), Home Health Care, Mental Health, except as provided in this Certificate, and Human Organ and Tissue Transplants;
65. Language training for educational, psychological or speech delays;
66. Diversional, recreational or vocational therapies such as hobbies, arts and crafts;
67. Cardiac rehabilitation home programs, on-going conditioning and maintenance;
68. Self-administered drugs purchased through or provided by a physicians office;
69. Massage therapy services

## 70. Acupuncture services

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

1. Performed at any Hospital that is not designated or approved by Us to provide Human Organ and Tissue Transplant services for the organ or tissue being transplanted;
2. If you are not a suitable candidate as determined by the Hospital designated and approved by Us to provide Human Organ and Tissue Transplant services;
3. For donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or for their respective family members or friends;
4. For any transplant, treatment, procedure, facility, equipment, drug, device, service or supply that requires federal or other governmental agency approval and such approval is not granted at the time services are provided, including any service or supply associated with or provided in follow-up;
5. For transplants of organs other than those listed in the **HUMAN ORGAN AND TISSUE TRANSPLANT** section of this Certificate including non-human organs;
6. Procurement of a donor organ which has been sold rather than donated;
7. Related to artificial and/or mechanical hearts or for subsequent services and supplies for a heart condition as long as any of the artificial or mechanical heart remains in place. This exclusion includes services for implantation, removal and complications.

### **Retail Pharmacy Prescription Drugs:**

1. Prescription Drugs and supplies received from an Out-of-Network pharmacy;
2. Prescription Drugs and supplies received as an inpatient in a hospital or other covered inpatient facility, except where covered as part of the inpatient stay;
3. Non-legend Prescription Drugs;
4. Drugs prescribed for weight control or appetite suppression;
5. Medication or preparations used for cosmetic purposes to promote hair growth, prevent hair growth, or medicated cosmetics. These included but are not limited to Rogaine®, Viniqa®, and Tretinoin (sold under such brand names as Retin-A®);
6. Any drug, product or technology within six (6) months of Food and Drug Administration (FDA) approval. We may, at Our sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology;
7. Any medications used to treat infertility;
8. Delivery charges for prescriptions;
9. Charges for the administration of any drug unless dispensed in the Physician's office or through Home Health Care;
10. Drugs which are provided as samples to the Provider;
11. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse;
12. Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of the **PRESCRIPTION DRUG** section;
13. Therapeutic devices or appliances, including support garments and other nonmedicinal supplies (regardless of intended use);
14. Nonprescription and over-the-counter drugs, including herbal or homeopathic preparations, and Prescription **Error! Bookmark not defined.** Drugs that have a clinically equivalent alternative, even if written as a prescription;
15. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) except for injectable insulin;

16. Prescription drug, which are dispensed in quantities or refill frequency which exceed the applicable limits established by Us, at Our sole discretion;
17. Refills of prescriptions in excess of the quantity prescribed by the Provider, or refilled more than one year from the date prescribed;
18. Prescription Drugs dispensed for the purpose of international travel;
19. Prescription Drugs which have been obtained through a Home Health Agency;
20. Replacement of lost or stolen Prescription Drugs.

### **Specialty Pharmacy Drugs**

1. Specialty Pharmacy Drugs which are not provided through the specialty program, including but not limited to Specialty Pharmacy Drugs that are provided through a Physician's office or Home Health Agency.
2. When benefits are provided under the Specialty Pharmacy benefits they will not be provided under the **Retail Pharmacy Prescription Drug** section of this certificate.
3. Outpatient prescription drugs or medications that are Specialty Pharmacy Drugs received from a Retail Pharmacy. You will pay the full cost of the Specialty Pharmacy Drug when received from a Retail Pharmacy since those services should have been received from a Specialty Pharmacy.

## ADMINISTRATIVE INFORMATION

### Insurance Premiums

**How Premiums are Established and Changed** - Premiums are the monthly charges you and/or the employer must pay Us to establish and maintain coverage. We determine and establish the required Premiums.

The employer is responsible for paying the employee's Premium to Us according to the terms of the Employer Master Contract. Employers may require their employees to contribute to the Premium cost through payroll deduction. **Grace Period** - If an employer fails to submit Premium payments to Us in a timely manner, the employer is entitled to a grace period of 31 days for the payment of such Premium. During the grace period, Our contract with the employer shall continue in force unless the employer gives Us written notice of termination of the contract. If the employer has obtained replacement coverage during the grace period, the contract with Us will be terminated as of the last day for which We have received Premium, and any and **all claims paid during the grace period will be retroactively adjusted to deny**, unless the Provider verified eligibility within two business days before each service received. These claims that We retroactively deny should be submitted to the replacement carrier. If the employer has **not** obtained replacement coverage during the grace period, or fails to inform Us that the employer has not obtained replacement coverage, we will process any and all claims with dates of service during the grace period in accordance with the terms of this Certificate.

### How to File Claims

When a PPO or Participating Provider bills Us for Covered Services, We will pay the appropriate charges for the benefit directly to the Provider. You are responsible for providing the PPO or Participating Provider with all information necessary for the Provider to submit a claim. You pay the applicable Deductible, and/or Coinsurance and/or Copayment to the Provider when the Covered Service is received.

If a Non-Participating Provider does not bill Us directly, you must file the claim. To obtain claim forms, contact Our customer service department or obtain from our web site at [www.anthem.com](http://www.anthem.com). If We do not furnish a claim form to you within 15 days of your request, you may submit written proof of the claim and will be considered to have complied with the requirements of this Certificate for submitting a claim. You must complete the claim form and attach the itemized bill from the Provider. Balance due statements, cash register receipts and cancelled checks are not accepted. All information on the claim form and itemized bill must be readable. When traveling outside the country, you should obtain itemized bills translated to English. Charges for Covered Services should be stated in terms of United States currency. To determine the United State currency amount, use the exchange rate as it was on the date you received care. If information is missing on the claim form or is not readable, the form will be returned to you. The information contained on the itemized bills will be used to determine benefits, so it must support information reported on the submitted claim form. The claim form contains detailed instructions on how to complete the form and what information is necessary.

We pay the benefits of this Certificate directly to Participating and Non-Participating Providers, when an assignment of benefits has been authorized. We may require a copy of the assignment of benefits for Our records. If We pay you directly, you are responsible for paying the provider of services for all charges. These payments fulfill our obligation to you for those services.

A separate claim form is required for each Non-Participating Provider for which you are requesting reimbursement.

A separate claim form is required for each Member when charges for more than one family Member are being submitted.

When you obtain health care services through BlueCard<sup>®</sup> outside the geographic area We serve, the amount you pay for Covered Services is calculated on the **lower** of:

- The Billed Charges for the Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to Us.

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

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard<sup>®</sup>

method noted above or require a surcharge, We will then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received care.

You will be entitled to benefits for health care services you received either inside or outside the geographic area We serve if this Certificate covers those health care services. Due to variations in Host Blue medical practice protocols, you may also be entitled to benefits for some health care services obtained outside the geographic area We serve, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area We serve. But in no event will you be entitled to benefits for health care services wherever you received them that are specifically excluded or limited from coverage by this Certificate.

**Where and When to Send Claims** - A claim must be filed **within 365 days** after the date of service. Any claims filed after this limit may be refused. Failure to file a claim within such time will not invalidate or reduce any claim if it is shown that it was not reasonably possible to give such notice and that notice was given as soon as reasonably possible.

Claims will be processed in accordance with the time frame as required by state law for the prompt payment of claims, to the extent such laws are applicable.

You should make copies of the bills for your own records and attach the original bills to the completed claim form. The bills and the claim form must be submitted to the following address:

Anthem Claims  
P.O. Box 17849  
Denver, CO 80217-0849

Upon your death, any claims payable to you under the terms of this Certificate will be payable in accordance with the beneficiary designation. If no such designation is in effect, any claims payable to you will be paid to your estate. If the Provider is a PPO or Participating Provider, claims payments will be made to the Provider.

**Payment in Error** - If We make an erroneous benefit payment, We may require you, the Provider of services or the ineligible person to refund the amount paid in error. We reserve the right to correct payments made in error by offsetting the amount paid in error against new claims. We also reserves the right to take legal action to correct payments made in error.

## General Provisions

**Catastrophic Events** - In case of fire, flood, war, civil disturbance, court order, strike, an act of terrorism or other cause beyond Our control, We may be unable to process your claims on a timely basis. No legal action or lawsuit may be taken against Us due to a delay caused by any of these events.

**Changes to the Certificate** - For employer groups of one to 50, if We amend this Certificate to modify benefits, notice of the amendment will be given to the employer no less than 90 days before to the Effective Date of such change and the amendment(s) will be effective for each group on the renewal or Anniversary Date of the policy.

For all other modifications, such as modifications due to state or federal law or regulation, We may amend this Certificate when authorized by one of Our officers. We will provide the employer with any amendments within 60 days following the Effective Date of the amendment. If the employer requests a change that reduces or eliminates coverage, such change must be requested in writing or signed by the employer. The employer will notify you of such change(s) to coverage. We or the employer will subsequently send or make available to you an amendment to this Certificate or a new Certificate.

No agent or employee of Ours may change this Certificate by giving incomplete or incorrect information, or by contradicting the terms of this Certificate. Any such situation will not prevent Us from administering this Certificate in strict accordance with its terms. Oral or written statements do not supersede the terms of this Certificate.

**Contracting Entity** - You hereby expressly acknowledges that you understand that the Certificate constitutes a contract solely between you and Us. We are an independent corporation operating under a license from the Blue Cross and Blue Shield Association, which is an association of independent Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits Us to use the Blue Cross and Blue Shield Service Mark, and in doing so, We are not contracting as the agent of the Blue Cross and Blue Shield Association. The Subscriber further acknowledges and agrees that the Subscriber has not entered into the contract based on representations by any person other than one of Our representatives, and that no person, entity or organization other than Us will be held accountable or liable to the Subscriber for any of Our obligations created under the Certificate. This paragraph does not create any additional obligations whatsoever on Our part other than those obligations created under other provisions of the Certificate.

**Decision Makers** - In some instances, if appropriate, We will recognize others as surrogate decision-makers to make decisions related to you health insurance coverage as required by state law. We require documentation as required by law for this authorization or appointment.

**Fraudulent Insurance Acts** - It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Insurance fraud results in cost increases for health care coverage. You can help decrease these costs by doing the following:

- Be wary of offers to waive Copayments. This practice is usually illegal.
- Be wary of mobile health testing labs. Ask what the insurance company will be charged for the tests
- Always review the Explanation of Benefits received from Us. If there are any discrepancies, call Our customer service department
- Be very cautious about giving your health insurance coverage information over the phone

If fraud is suspected, you should contact Our customer service department.

We reserve the right to recoup any benefit payments paid on your behalf, and/or rescinding your membership under this Certificate retroactively as if it never existed if you have committed fraud or material misrepresentation in applying for coverage in or receiving or filing for benefits.

**Independent Contractors** - We have an independent contractor relationship with Our PPO or Participating Providers; Physicians and other Providers are not Our agents or employees, and We and Our employees are not employees or agents of any of Our PPO or Participating Providers. We have no control over any diagnosis, treatment, care or other service provided to you by any Facility or Professional Providers. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries you suffer while receiving care from any of Our PPO or Participating Providers by reason of negligence or otherwise.

We have an independent contractor relationship with your employer. The employer is not Our agent or employee, and We and Our employees are not employees or agents of the employer.

We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited, to prescription drugs, mental health, Alcohol Dependency and Substance Dependency services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims payment or customer service duties on Our behalf.

**Members Obligation to Supply Information and Cooperate** – You must provide Us with any information We consider necessary to determine whether, or to what extent, services are covered under this Certificate, or to carry out the other provisions of this Certificate.

You agree to cooperate at all times (including while you are hospitalized) by allowing Us access to your medical records to investigate claims and verify information provided in your Enrollment Application/Change Form and/or Health Statement.

If you do not supply information or cooperate as described above, We may deny the claims subject to investigation and We, where permitted by law, may terminate your coverage.

**Medicare** – Any benefits covered under both this Certificate and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Health Care Financing Administration guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Certificate provisions, and federal law. Except when federal law require Us to be the primary payor, the benefits under this Certificate if you are age 65 and older, do not duplicate any benefit for which you are entitled under Medicare, including Part B. We will coordinate benefits with Medicare consistent with state and federal law. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to Us, to the extent We have made payment for such services.

**Network Access Plan** – We strive to provide Provider network in Colorado that adequately addresses your health care needs. The Network Access Plan describes Our Provider network standards for network sufficiency in service, access and availability, as well as assessment procedures We follow in Our effort to maintain adequate and accessible networks. To request a copy of this document, call Our customer service department. This document is also available on Our website or for in-person review at 700 Broadway in Denver, Colorado, in the customer service department.

**Non-Contestable** - This Certificate shall not be contested, except for nonpayment of Premiums by the employer, after it has been in force for two years from its date of issue. No statement made to effect coverage under the Certificate with respect to a Member shall be used to avoid the insurance with respect to which statement was made or to reduce benefits under such Certificate after such insurance had been in force for a period of two years during such Member's lifetime, unless such statement is contained in a written instrument signed by the Member making such statement and a copy of that instrument is or has been furnished to the Member making the statement or to the beneficiary of any such Member.

**Notice of Privacy Practices** –We are committed to protecting the confidential nature of your medical information to the fullest extent of the law. In addition to various laws governing your privacy, We have our own privacy policies and procedures in place designed to protect your information. We are required by law to provide individuals with notice of Our legal duties and privacy practices. To obtain a copy of this notice, visit Our website at [www.anthem.com](http://www.anthem.com) or contact Our customer service department.

**No Withholding of Coverage for Necessary Care** - We do not compensate, reward or incent, financially or otherwise, Our associates for inappropriate restrictions of care. We do not promote or otherwise provide an incentive to employees or Physician reviewers for withholding benefit approval for Medically Necessary services to which you are entitled. Utilization Review and benefit coverage decision making is based on appropriateness of care and service and the applicable terms of this Certificate.

We do not design, calculate, award or permit financial or other incentives based on the frequency of: denials of Authorization for coverage; reductions or limitations on Hospital lengths of stay, medical services or charges; or telephone calls or other contacts with you or your health care Providers.

**Paragraph Headings** - The headings used throughout this Certificate are for reference only and are not to be used by themselves for interpreting the provisions of the Certificate.

**Physical Examinations and Autopsies** - We have the right and opportunity, at Our expense, to request an examination of a person covered by Us when and as often as it may reasonably be required during the review of a case or claim. On the death of a Member, We may request an autopsy where it is not forbidden by law.

**Research Fees** - We reserve the right to charge an administrative fee when extensive research is necessary to reconstruct information that has already been provided to you in explanations of benefits, letters or other documents.

**Reserve Funds** – You are not entitled to share in any reserve or other funds that may be accumulated or established by Us, unless We grant a right to share in such funds.

**Sending Notices** - All Subscriber notices are considered sent to and received by the Subscriber when deposited in the United States mail with postage prepaid and addressed to either one of the following:

- The Subscriber at the latest address in Our membership records
- The Subscriber's employer, if applicable

## **Workers' Compensation**

To recover benefits under workers' compensation insurance for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the employer liability laws that may apply. This includes filing an Appeal with the Division of Workers' Compensation. We may pay conditional claims during the Appeal process if you sign a reimbursement agreement to reimburse Us for 100 percent of benefits paid that duplicate benefits paid from another source.

**Services and supplies resulting from work-related illness or injury are not a benefit under this Certificate**, except for corporate officers who have opted out of Workers' Compensation coverage, pursuant to state or federal law, prior to the illness or injury. This exclusion from coverage applies to expenses resulting from occupational accident(s) or sickness(es) covered under the following:

- Occupational disease laws
- Employer's liability insurance
- Municipal, state, or federal law
- The Workers' Compensation Act

We will not pay benefits for services and supplies resulting from a work-related illness or injury **even if other benefits are not paid because:**

- You fail to file a claim within the filing period allowed by the applicable law
- You obtain care that is not authorized by workers' compensation insurance
- Your employer fails to carry the required workers' compensation insurance. In this case, the employer becomes liable for any of the employee's work-related illness or injury expenses.
- You fail to comply with any other provisions of the Workers' Compensation Act

### **Automobile Insurance Provisions**

We will coordinate the benefits of this Certificate with the benefits of a complying automobile insurance policy.

A complying automobile insurance policy is an insurance policy approved by the Colorado Division of Insurance that provides at least the minimum coverage required by law, and one which is subject to the Colorado Auto Accident Reparations Act or Colorado Revised Statutes §§ 10-4-601 through 10-4-633. Any state or federal law requiring similar benefits through legislation or regulation is also considered a complying policy.

**How We Coordinate Benefits with Complying Policies** - Your benefits under this Certificate may be coordinated with the coverage's afforded by a complying policy. After any primary coverage's offered by the complying policy are exhausted, , We will pay benefits subject to the terms and conditions of this Certificate. If there is more than one complying policy that offers primary coverage, each will pay its maximum coverage before We are liable for any further payments.

You must fully cooperate with Us to make sure that the complying policy has paid all required benefits. We may require you to take a physical examination in disputed cases. If there is a complying policy in effect, and you waive or fail to assert the member's rights to such benefits, this Plan will not pay those benefits that could be available under a complying policy.

We may require proof that the complying policy has paid all primary benefits prior to making any payments to you. Alternatively, We may but are not required to pay benefits under this Certificate, and later coordinate with or seek reimbursement under the complying policy. In all cases, upon payment, We are entitled to exercise Our rights under this Certificate and under applicable law against any and all potentially responsible parties or insurers. In that event, We may exercise the rights found in the **ADMINISTRATIVE INFORMATION** section, under the heading *Third Party Liability: Subrogation and Right of Reimbursement*.

**What Happens If You Do Not Have Another Policy** –We will pay benefits for injuries you receive while you are riding in or operating a motor vehicle that you own if the vehicle is not covered by an automobile complying policy as required by law.

We will also pay benefits under the terms of the Certificate for injuries you sustain if you are a non-owner-operator, passenger or pedestrian involved in a motor vehicle accident if your injuries are not covered by a complying policy. In that event, We may exercise the rights found in the **ADMINISTRATIVE INFORMATION** section, under the heading *Third Party Liability: Subrogation and Right of Reimbursement*.

### **Third Party Liability: Subrogation and Right of Reimbursement**

These provisions apply when We pay benefits as a result of injuries or illness and another party or party(ies) agrees or is ordered to pay money because of these injuries or when the Member received or is entitled to receive a Recovery because of these injuries or illnesses.

#### **Subrogation**

We have the right to recover payments We make on your behalf. The following apply:

- We have the first priority lien for the full amount of benefits We have paid from any Recovery, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, your own insurer (for example, uninsured, underinsured, medical payments or no-fault coverage, or a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness. Our first priority lien exists regardless of whether you are fully compensated, and regardless of whether the payments you receive makes you whole for losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.

- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Certificate.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, beneficiary's claims (if applicable), your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs incurred without Our prior written consent. You and We further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney hired regardless of whether funds recovered are used to repay benefits paid by Us.

### **Right of Reimbursement**

If you, your legal representative, or beneficiary obtain a Recovery and We have not been repaid for the benefits We paid on the Member's behalf, We shall have a first priority lien right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on the Member's behalf from any Recovery, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, your own insurer (for example, underinsured, medical payments or no-fault coverage, or a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You, your legal representative, or beneficiary must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon receipt of the Recovery. You, your legal representative, or beneficiary must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you, your legal representative, or beneficiary may hire regardless of whether funds recovered are used to repay benefits paid by Us.

If you, your legal representative, or a beneficiary fails to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of any Recovery whichever is less, from any future benefit under the Certificate if:

- The amount We paid is not repaid or otherwise recovered by Us; or
- You fail to cooperate or otherwise fulfill your duties, as described in this Certificate.
- In the event you, your legal representative, or a beneficiary fails to disclose to Us the amount of any settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Certificate.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of any settlement, whichever is less, directly from the providers to whom We have made payments, to the extent not prohibited by law. In such a circumstance, it may then be the obligation of you, your legal representative, or beneficiary to pay the provider the full outstanding amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make to you or the recovering party whole.

### **The Member's Duties**

- You, your legal representative, or beneficiary must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You, your legal representative, or beneficiary must cooperate with Us in the investigation, settlement and protection of its rights.
- You, your legal representative, or beneficiary must not do anything to prejudice Our rights.
- You, your legal representative, or beneficiary must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness.

- You, your legal representative, or beneficiary must promptly notify Us if you retain an attorney or if a lawsuit is filed
- If you, your legal representative, or beneficiary resides in a state where automobile personal injury protection or medical payment coverage is mandatory, that coverage is primary and the Certificate takes secondary status. The Certificate will reduce benefits for an amount equal to, but not less than, that state's mandatory minimum personal injury protection or medical payment requirement.

NOTE: Failure to comply with obligations in this section may result in termination of coverage under this Certificate.

## **Duplicate Coverage and Coordination of Benefits**

We coordinate benefits when you have duplicate coverage.

**Duplicate Coverage** - Duplicate coverage exists when you are covered by this coverage and also covered by another group or group-type health insurance or health care benefits coverage or blanket coverage. The total benefits received by you, or on your behalf, from all coverage's combined for any claim for Covered Services will not exceed 100 percent of the total covered charges.

**How We Determine Which Coverage is Primary and Which is Secondary** - We will determine the primary coverage and secondary coverage according to the following rule: A coverage is primary if it does not have order of benefit determination rules or if it has rules that differ from those permitted by state law.

**Duplicate Coverage on Members** - A coverage is primary if the Member claiming benefits is the person in whose name the policy is issued but who is not a Dependent under that coverage (except when covered by Medicare or COBRA).

The benefits of a coverage which covers a person as an employee who is not laid-off or retired (or as that employee's Dependent) is primary before benefits of a coverage which covers that person as a laid-off or retired employee (or as that employee's Dependent).

When you (including your Dependent family Members) have duplicate coverage carried through two or more employers, the policy that has been in force the longest period of time is primary. The policy that has been in force the shortest period of time is secondary.

When the coverage through one of the employers is a COBRA policy and one of the coverage's is through active employment, the coverage through active employment is primary.

NOTE: Change in plan administrators is considered continuous coverage. Therefore, the Effective Date of the coverage in that group is the Effective Date with the original carrier who provided insurance, as long as there were no lapses in coverage. Information about coordinating benefits for Members who hold two insurance policies and Medicare may be found under the "Members with Medicare and Two Group Insurance Policies" heading in this section.

**Duplicate Coverage on Spouses** - When your Spouse has group coverage through an employer and is actively working, that coverage is primary for the Spouse.

When the coverage carried by the Spouse is through retiree or inactive employment, that coverage will be primary over the coverage carried by Our Subscriber.

When the Spouse's coverage through the employer is a COBRA policy and Our coverage is active, then the Spouse's COBRA coverage will be secondary to Our policy.

Note: Information about coordinating benefits for Members who hold two insurance policies and Medicare may be found under the heading "Members with Medicare and Two Group Insurance Policies" heading in this section.

**Duplicate Coverage on Dependent Children (when parents are not separated or divorced)** - If both coverage's cover the child as a Dependent, the benefits of the coverage of the parent whose birthday occurs earlier in the year is primary ("Birthday Rule") over those of the coverage of the parent whose birthday falls later in that year. However, if both parents have the same birthday (month and day, not year), then the benefits of the coverage that has covered **the parent** and Dependent(s) longest is primary over the coverage which has covered the **other parent** and Dependent(s) for a shorter period of time.

If either insurance policy does not follow the Birthday Rule, the male policyholder's insurance is the primary policy.

**Duplicate Coverage on Dependent Children (when parents are separated or divorced)** - We require a copy of the divorce decree to establish primacy on children of divorced parents.

When the specific terms of a court decree state that one of the parents is responsible for providing health insurance for the child that insurance policy is primary. The insurance policy of the other parent is the secondary coverage.

The insurance policy of the parent with legal custody of the child is primary. When the parent with custody remarries, the custodial parent's coverage remains primary. The stepparent's coverage becomes secondary, and the coverage of the parent without custody pays **after** the stepparent's coverage.

The Birthday Rule (benefits of the coverage of the parent whose birthday occurs earlier in the year are primary) applies when the specific terms of the court decree state that the parents share joint custody and both must provide health insurance.

The Birthday Rule applies when the specific terms of the court decree state that the parents share joint custody, without stating which parent is responsible for providing health insurance for the child.

When the divorce decree states that one of the parents is responsible for providing health insurance and the parents share joint custody, then the parent providing the coverage will be primary.

**How We Coordinate Benefits** - When We are the primary coverage, We pay benefits under the terms of this Certificate. When We are the secondary coverage, We may pay up to the difference between benefits that would be payable by the primary coverage and the amount that would be payable under this Certificate in the absence of a Coordination of Benefits provision, so long as that difference is not more than We would normally pay. Benefits provided under any other coverage include benefits that would have been provided had a claim been made for these benefits.

**Determining Primacy Between Medicare and Us** – We will be the primary payer for persons age 65 and older with Medicare coverage if the policyholder is actively working for an employer who is providing the policyholder's health insurance and the employer has 20 or more employees. Medicare will be the primary payer for persons age 65 and older with Medicare coverage if the policyholder is not actively working and the member is enrolled in Medicare. Medicare will be the primary payer for persons with Medicare age 65 and older if the employer has less than 20 employees and the member is enrolled in Medicare.

We will be the primary payer for persons under age 65 with Medicare coverage when Medicare coverage is due to disability if the policyholder is actively working for an employer who is providing the policyholder's health insurance and the employer has 100 or more employees. Medicare will be the primary payer for persons enrolled with Medicare due to disability if the policyholder is not actively working or the employer has less than 100 employees.

We will be the primary payer for persons under age 65 with Medicare coverage when Medicare coverage is due to End Stage Renal Disease (ESRD), for the first 30 months from the **entitlement to** or **eligibility for** Medicare (whether or not Medicare is taken at that time). After 30 months, Medicare will become the primary payer if Medicare is in effect (30-month coordination period).

When a Member becomes eligible for Medicare due to a second entitlement (such as age), We remain primary, if the group health care coverage was primary at the point when the second entitlement became effective, for the duration of 30 months after the Medicare entitlement or eligibility due to ESRD. If Medicare was primary at the point of the second entitlement, then Medicare remains primary. There will be no 30-month coordination period for ESRD.

**Members with Medicare and Two Group Insurance Policies** - If Medicare is secondary to a group coverage (see Medicare primacy rules), the primary coverage covering the Member will pay first, Medicare will pay second, and the coverage covering the Member as a retiree or inactive employee or Dependent will pay third. The order of primacy is not based on the group health insurance policyholder.

If Medicare is the primary payer due to Medicare primacy rules, then the rules of primacy for employees and their Spouses will be used to determine the coverage that will pay second and third. The rules of primacy can be found under the heading "Double Coverage on Spouses."

**Your Obligations** – You have an obligation to provide Us with current and accurate information regarding the existence of other coverage.

Benefits payable under another coverage include benefits that would be payable under that coverage, whether or not a claim is made, and benefits that would have been paid but were refused because the claim was not sent to the Provider of other coverage on a timely basis.

Your benefits under this Certificate will be reduced by the amount that such benefits would duplicate benefits payable under the primary coverage.

**Payment of Benefits to Others** - Whenever payments that should have been made under this Certificate have been made under any other coverage, We will have the right to pay to the other coverage any amount We determine to be warranted to satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this Certificate, and with that payment We will fully satisfy Our liability under this provision.

**Our Right of Overpayment Recovery** - If We have overpaid for Covered Services under this provision, We will have the right, by offset or otherwise, to recover the excess amount from you or any person or entity to which, or on whose behalf, the payments were made.

## COMPLAINTS, APPEALS AND GRIEVANCES

This section explains what to do if you disagree with Our denial, in whole or in part, of a claim or requested service or supply and it includes instructions for initiating a Complaint, filing an Appeal or filing a Grievance with Us.

### Complaints

If you have a Complaint about any aspect of Our service or claims processing, you should contact Our customer service department. A trained representative will work to clear up any confusion and resolve your concerns. You may submit a written Complaint to the address listed below. If you are not satisfied with the resolution of Member concerns by Our customer service associate, you may file an Appeal as explained under the **Appeals** heading in this section:

Anthem  
Customer Service Department  
P.O. Box 17549  
Denver, CO 80217-0549

### Appeals

Your Appeal must be submitted in writing. While We encourage you to file Appeals within 60 days of the adverse benefit determination, your written Appeal must be received by Us within 180 days of the adverse benefit determination. Appeals may be for pre-service denials or post-service denials. We will assign a customer advocate to assist you in the Appeal process. You must send written Appeals to the following address:

Anthem  
Appeals Department  
700 Broadway CAT CO0104-0430  
Denver, CO 80273-0001

An Appeal may be filed with or without first submitting a complaint. In the Appeal, you must state plainly the reason(s) why the claim or requested service or supply should not have been denied. You should include any documents not originally submitted with the claim or request for the service or supply and any information that may have a bearing on our decision.

For a thorough, unbiased review, you may access two internal levels of Appeal. In the case of a benefit denial based on utilization review, an independent external review Appeal is also available to you. For pre-service denials based on utilization review, an expedited Appeal and expedited independent external review may be available in certain circumstances.

You may designate a representative (e.g., your Physician or anyone else of your choosing) to file any level of Appeal review with us on your behalf. You must give this designation to us in writing.

The Appeals process is governed by laws and regulations, and may be modified from time to time by Us as those laws may require. A more detailed description of the Appeals process and the decision timeframes is set forth in our Appeals guide. This guide is available through our website or may be obtained free of charge by calling customer service.

### Grievances

A Member may send a written Grievance to the following address:

Anthem  
Quality Management Department  
700 Broadway CO0105-0532  
Denver, CO 80273-0001

Receipt of your Grievance will be acknowledged by Our quality management department which will investigate the Grievance. We treat each Grievance investigation in a strictly confidential manner.

### Division of Insurance Inquiries

For inquiries about health care coverage in Colorado, you may call the Division of Insurance between 8:00 a.m. and 5:00 p.m., Monday through Friday, at (303) 894-7490, or write to the Division of Insurance to the attention of the ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202.

## **Binding Arbitration**

The binding arbitration provision under this Certificate is applicable to claims arising under all individual plans, governmental plans, church plans, plans or claims to which ERISA preemption does not apply, and plans maintained outside the United States. Any such arbitration will be governed by the procedures and rules established by the American Arbitration Association. You may obtain a copy of the Rules of Arbitration by calling Our customer service department. The law of the state in which the policy was issued and delivered to you shall govern the dispute. The arbitration decision is binding on both you and Us. Judgment on the award made in arbitration may be enforced in any court with proper jurisdiction. In any person subject to this arbitration clause initiates legal action of any kind, the other party may apply for a court of competent jurisdiction to enjoin, stay or dismiss any such action and direct the parties to arbitrate in accordance with this provision.

## **Legal Action**

Before you take legal action on a claim decision, you must first follow the process outlined under the **Appeals** heading in this section and you must meet all the requirements of this Certificate.

No action in law or in equity shall be brought to recover on this Certificate before the expiration of 60 calendar days after a claim has been filed in accordance with the requirements of this Certificate. No such action shall be brought at all unless brought within three years after claim has been filed as required by the Certificate.

## GLOSSARY

This section defines words and terms used throughout the Certificate to help you understand the content. The first letter of each of these words will be capitalized whenever it is used as a defined below in this Certificate. You should refer to this section to find out exactly how, for the purposes of this Certificate, a word or term is used, for the purposes of this Certificate.

**Accidental Injuries** - unintentional internal or external injuries, e.g., strains, animal bites, burns, contusions and abrasions which result in trauma to the body. Accidental Injuries are different from illness-related conditions.

**Acupuncture Services** - the treatment of a disease or condition by inserting special needles along specific nerve pathways for therapeutic purposes. The placement of the needles varies with the disease or condition being treated.

**Acute Care** - care that is provided in an office, Urgent Care setting, Emergency room or Hospital for a medical illness, accident or injury. Acute Care may be Emergency, urgent or non-urgent, but is not primarily preventive in nature.

**Acute Rehabilitation Therapy** - inpatient rehabilitation therapy that is required for a short period of time. Acute rehabilitation therapy services are unrelated to acute hospital medical or surgical care.

**Alcohol Dependency** - means is a condition brought about when an individual uses alcohol in such a manner that his or her health is impaired and/or ability to control actions is lost.

**Alcoholism/Substance Treatment Center** - a detoxification and/or rehabilitation facility licensed by the state to treat alcoholism/drug dependency.

**Alternative Care Facility** – a non-Hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient services primarily for but not limited to:

- Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
- Surgery;
- Therapy Services or Rehabilitation

An Alternative Care Facility is not related to the delivery of Alternative/Complimentary Care as defined below.

**Alternative/Complimentary Care** - therapeutic practices that are not currently considered an integral part of conventional medical practice. Therapies are termed *Complimentary* when used in addition to conventional treatments and as alternative when used instead of conventional treatment. Alternative medicine includes, but is not limited to, Chinese or Ayurvedic medicine, herbal treatments, vitamin therapy, homeopathic medicine and other non-traditional remedies for treating diseases or conditions.

**Ambulance** - a specially designed and equipped vehicle used **only** for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained personnel and licensed as an Ambulance.

**Ancillary Services** - services and supplies (in addition to room services) that Hospitals, Alcoholism Treatment Centers and other facilities bill for and regularly make available for the treatment of your condition. Such services include, but are not limited to:

- Use of operating room, recovery room, Emergency room, treatment rooms and related equipment
- Drugs and medicines, biologics (medicines made from living organisms and their products), and pharmaceuticals
- Dressings and supplies, sterile trays, casts, and splints
- Diagnostic and therapeutic services
- Blood processing and transportation and blood handling costs and administration

**Anesthesia** - the loss of normal sensation or feeling. There are two different types of Anesthesia:

- General Anesthesia, also known as total body Anesthesia, causes the patient to become unconscious or “put to sleep” for a period of time
- Local Anesthesia causes loss of feeling or numbness in a specific area and is usually injected with a local anesthetic drug such as Lidocaine

**Anniversary Date** - the annual date on which a group renews its coverage.

**Anthem Blue Cross and Blue Shield** - Rocky Mountain Hospital Medical Service, Inc., a Colorado company doing business as Anthem Blue Cross and Blue Shield. Also referred to in this Certificate as “Anthem”, “Us”, “We” or “Our”.

**Appeal** - a process for reconsideration of Our decision regarding your claim.

**Authorization** - approval of benefits for a covered procedure or service.

**Benefit Period** — Your Benefit Period begins on your effective date, and expires on the following June 30; a new Benefit Period commences on each subsequent July 1.

**Benefit Period Maximum** - The maximum number of days, visits or dollar amount We will pay for specific Covered Services during a Benefit Period.

**Billed Charges** - a Provider’s regular charges for services and supplies as offered to the public generally and without any adjustment for any applicable PPO or Participating Provider or other discounts.

**Biologically Based Mental Illnesses** - are schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder and panic disorder.

**Birth Abnormality** - a condition that is recognizable at birth, such as a fractured arm.

**Birthdate Rule** - the guideline that determines which of two parents' health insurance coverage's is primary for the coverage of Dependent child(ren). Generally, under the Birthdate Rule, the parent whose birthday comes first during the year is considered to have the primary insurance coverage for the child(ren). Any balance may be submitted to the other parent's insurance carrier for additional consideration.

**Cardiac Rehabilitation** - medically supervised, planned program to increase the functional capacity of the patient to allow the individual to resume activities of daily living after a cardiac event.

**Care Management** - a plan of Medically Necessary and appropriate health care which is aimed at promoting more effective interventions to meet your needs and optimize care. Care Management is also referred to as case management.

**Care Manager** - a professional (e.g., nurse, doctor or social worker) who works with you, your Providers and Us to coordinate services deemed Medically Necessary for your care. A Care Manager is also referred to as a case manager.

**Certificate** - this document, which explains the benefits, limitations, exclusions, terms and conditions of the health care coverage.

**Chemotherapy** - drug therapy administered as treatment for malignant conditions and diseases of certain body systems.

**Chiropractic Services** - a system of therapy in which disease is considered the result of abnormal function of the nervous system. This method of treatment usually involves manipulation of the spinal column and other body structures.

**Chronic Pain** - ongoing pain that lasts more than six months that is due to non-life threatening causes, may continue for the remainder of the person's life, and has not responded to current available treatment methods.

**Chronic Rehabilitation Therapy** - inpatient rehabilitation therapy that is required for more than six months and may continue for the remainder of the person's life. Chronic rehabilitation therapy is also known as non-acute and long-term acute.

**Clinically Equivalent** - means drugs as determined by Us that, for the majority of members, can be expected to produce similar therapeutic outcomes for a disease or condition.

**COBRA** - an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law allows individuals, in certain cases, to continue their group health insurance coverage for a specified period after termination of their employment or due to a qualifying events.

**Coinsurance** – a provision under which you share costs with Us after the Deductible is met, according to a specific formula. The amount of Coinsurance you pay to a Provider is calculated after the determination of the Maximum Benefit Allowance, but after We subtract any discount(s) We may have negotiated with the Provider.

**Cold Therapy** - the application of cold to decrease swelling, pain or muscle spasm.

**Common Law Spouse** - an eligible dependent who has a valid Common-Law marriage in the state of Colorado which is for all purposes the same as a ceremonial marriage and can only be terminated by death or divorce.

**Complaint** — an expression of dissatisfaction with Our services or the practices of an PPO Provider or Participating Provider, whether medical or non-medical in nature.

**Congenital Defect** – a defect or anomaly existing before birth, such as cleft lip or club foot. Disorders of growth and development over time are not considered congenital.

**Consultation/Second Opinion** - a service provided by another Physician who gives an opinion about the treatment of your condition. The consulting Physician often has specialized skills that are helpful in diagnosing or treating the illness or injury.

**Coordination of Benefits** - also known as COB, a stipulation in most health insurance policies that helps prevent duplicate payments for services covered by more than one policy or program of insurance. For example, you may be covered by your own policy, as well as a Spouse's policy. Eligible medical expenses are covered first by the person's own policy. Any balance is submitted to the Spouse's health insurance carrier for additional consideration.

**Copayment** - the portion of a claim or medical expense that you must pay out of your own pocket to a Provider or a facility for each service. A Copayment is usually a fixed amount or can be a percentage paid at the time the service is rendered.

**Cosmetic Services** - beautification procedures, services or Surgery performed on a physical characteristic to improve an individual's appearance.

**Cost Sharing** - the general term used for out-of-pocket expenses you pay, e.g. Copayments, and Deductibles paid by you.

**Covered Services** - services, supplies or treatments which are:

- Medically Necessary or otherwise specifically included as a benefit under this Certificate
- Within the scope of the license of the Provider performing the service
- Rendered while coverage under this Certificate is in force
- Not Experimental/Investigational or otherwise excluded or limited by the Certificate, or by any amendment or rider thereto
- Authorized in advance by Us if such Preauthorization is required by the Certificate

Covered Services are subject to the Maximum Benefit Allowance which is the maximum amount payable for Covered Services you receive, up to but not to exceed charges actually billed. If a service is not covered or if you have exceeded your benefits for Covered Services, the Provider is not limited by the Maximum Benefit Allowance and they can charge up to the billed amount.

**Creditable Coverage** - a qualified prior health coverage that a Member had within 90 days before the Effective Date of Our coverage. Prior creditable health coverage includes Medicare or Medicaid coverage, a group health insurance coverage, an individual health benefit coverage, state high risk pool coverage, any federal or state health benefit coverage or any other health benefit coverage that provides basic medical and Hospital care, including, but limited to, Hospital services, Physicians' services, outpatient medical services, and laboratory and x-ray services.

**Custodial Care** - care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes, but is not limited to, preparing food or special diets, feeding, administration of medicine that is usually self-administered or any other care that does not require continuing services of specialized medical personnel.

**Deductible** an amount that is required to be paid by you before We will begin to reimburse for services.

**Dental Services** - services performed for treatment of conditions related to the teeth or structures supporting the teeth.

**Dependent** - a Subscribers legal spouse or unmarried child as defined in the **MEMBERSHIP** section of this Certificate under the heading **Dependents**.

**Discharge Planning** - the evaluation of your medical needs and arrangement of appropriate care after discharge from a facility.

**Disease Management** - is used to help coordinate care for Members who have been diagnosed with specific, persistent or chronic conditions.

**Dialysis Treatment** - a medical procedure that filters the blood and removes excess fluids and waste products usually removed by the kidneys. It is a necessary form of treatment for patients with end stage renal disease.

**Durable Medical Equipment** - any equipment that can withstand repeated use, is made to serve a medical condition, is useless to a person who is not ill or injured, and is appropriate for use in the home.

**Effective Date** - the date coverage under this Certificate begins.

**Elective Surgery** - a procedure that does not have to be performed on an Emergency basis and can be reasonably delayed. Such Surgery may still be considered Medically Necessary.

**Emergency** - the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

**Employer Master Contract** - the agreement between Us and the employer stating all of the terms and provisions applicable to group coverage. The final interpretation of any specific provision contained in this Certificate is governed by the Employer Master Contract.

**Experimental/Investigational -**

(a) Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which We determine in Our sole discretion to be Experimental or Investigational.

We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be Experimental or Investigational if we determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted
- Has been determined by the FDA to be contraindicated for the specific use
- Is provided as part of a clinical research protocol or clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental or Investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation

(b) Any service not deemed Experimental or Investigational based on the criteria in subsection (a) may still be deemed to be Experimental or Investigational by Us. In determining whether a service is Experimental or Investigational, We will consider the information described in subsection (c) and assess all of the following:

- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes
- Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings

(c) The information We consider or evaluate to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental or Investigational under subsections (a) and (b) may include one or more items from the following list, which is not all-inclusive:

- Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies

- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- Documents of an IRB or other similar body performing substantially the same function
- Consent documentation(s) used by the treating Physicians, other medical professionals or facilities, or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- The written protocol(s) used by the treating Physicians, other medical professionals or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- Medical records
- The opinions of consulting Providers and other experts in the field

(d) We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental or Investigational.

**Explanation of Benefits** - also known as an EOB, a printed form sent by an insurance company to you after a claim has been filed and adjudicated. The EOB includes such information as the date of service, name of Provider, amount covered and patient balance. An explanation of Medicare benefits, or EOMB, is similar, except it is sent following submission of a Medicare claim.

**Family Membership** - a membership that covers two or more persons (the Subscriber and one or more Dependents).

**Grievance** - a written Complaint about the quality of care or service a Member receives from a Provider.

**Health Benefit ID Card** - the card We give you with information such as the Subscriber's name and Subscriber's ID number.

**Health Benefit Plan Description Form** - the document, found in the front of the Certificate, which identifies the type of coverage and Deductible, Copayment and Coinsurance information.

**Hemodialysis** - the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

**Holistic Medicine** - various preventive and healing techniques, that are theoretically based on the influence of the external environment and the various ways different body tissues affect each other along with the body's natural healing powers.

**Home Health Agency** - an agency certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal "Social Security Act" as amended, for Home Health Agencies. A Home Health Agency is primarily engaged in arranging and providing nursing services, home health aide services, and other therapeutic and related services.

**Home Care** - the general term for skilled nursing, Occupational Therapy and other health-related services provided at home by an accredited agency.

**Home Care Services** - professional nursing services, certified nurse aide services, Medical Supplies, equipment, and appliances suitable for use in the home, and Physical Therapy, Occupational Therapy, Speech Pathology and audiology services provided by a certified Home Health Agency to eligible Member's who are under a plan of care in their place of residence.

**Home IV Therapy** - services in the home as home intravenous (IV) chemotherapy, antibiotic therapy, or IV pain management.

**Hospice Facility** - a Facility Provider licensed by the Colorado Department of Public Health and Environment to provide Hospice Care in this state. A Hospice is a centrally administered program of palliative, supportive and interdisciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient care, Home Care and follow-up bereavement services available 24 hours a day, seven days a week.

**Hospice Care** - an alternative way of caring for terminally ill individuals that stresses palliative care rather than curative or restorative care. Hospice Care focuses on the patient/family as the unit of care. Supportive services are offered to the family before and after the death of the Member. Hospice Care addresses physical, social, psychological and spiritual needs of the Member and the Member's family.

**Hospital** - a health institution offering facilities, beds and continuous services 24 hours a day and that meets all licensing and certification requirements of local and state regulatory agencies.

**Host Blue** - another Blue Cross and/or Blue Shield licensee for health care services outside the Service Area in which We operate which provides In-Network services and claims processing.

**Human Organ and Tissue Transplants** — a surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of body substances, such as stem cells or bone marrow, for the purpose of treatment and reimplanting the removed organ or tissue into the same person.

**Individual Membership** - a membership covering one person (the Subscriber).

**Inhalation Therapy** - therapeutic use of medicines, aerosols, gases, water vapors or anesthetics by inhalation.

**In-Network** - a term describing Providers or facilities that enter into a PPO network agreement with Us .

**Intractable Pain** - a pain state in which the cause of the pain cannot be removed and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area, system or organ of the body perceived as the source of the pain.

**In-Vitro** - outside the body in an artificial environment.

**In-Vivo** - within the living body.

**Laboratory and Pathology Services** - testing procedures required for the diagnosis or treatment of a condition. Generally, these services involve the analysis of a specimen of tissue or other material that has been removed from the body.

**Lifetime Maximum** - the maximum dollar amount We will pay for Covered Services during your lifetime under Our Certificates. The Lifetime Maximum is listed on your *Health Benefit Plan Description Form*.

**Long-Term Acute Care Facility (LTC)** - an institution that provides an array of long-term critical care services if you have serious illnesses or injuries. Long-Term Acute Care is provided for Members with complex medical needs. These include Members with high-risk pulmonary condition who have ventilator or tracheotomy needs Members, medically unstable Members, extensive wound care needs or post operative Surgery wound care needs, and Members with low level closed head injuries. Long-Term Acute Care Facilities do not provide care for low intensity patient needs.

**Mail Service Pharmacy** - an establishment licensed to dispense Prescription Drugs and other medications (other than Specialty Pharmacy Drugs) through a mail order service upon an authorized health care professional's order.

**Managed Care** - a system of health care delivery the goals of which are to give you access to quality, cost-effective health care while optimizing utilization and cost of services, and measuring Provider and coverage performance.

**Maternity Services** - services you require for the diagnosis and care of a pregnancy, complications of pregnancy and for delivery services. Delivery services include:

- Normal vaginal delivery
- Cesarean section delivery
- Spontaneous termination of pregnancy before full term
- Therapeutic or elective termination of pregnancy before viability

**Maximum Benefit Allowance** - the maximum dollar amount We determine and approve which We allow for Covered Services and procedures. Our determination of a Maximum Benefit Allowance is the maximum amount We approve for any particular service. Cost Sharing amounts are based on this allowance and the amounts you pay to a Provider.

**Maximum Medical Improvement** - a determination at Our sole discretion that no further medical care can reasonably be expected to measurably improve your condition. Maximum Medical Improvement shall be determined without regard to whether continued care is necessary to prevent deterioration of the condition or is otherwise life-sustaining.

**Medical Provider Administered Specialty Drug List** - a list of Specialty Pharmacy Drugs as determined by HMO Colorado which must be obtained from Our In-Network Specialty Pharmacy affiliate and are billed under the medical benefit.

**Medical Supplies** - items (except Prescription Drugs) required for the treatment of an illness or injury.

**Medically Necessary** - an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that We solely determine to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury
- Obtained from a Physician and/or licensed, certified or registered Provider
- Provided in accordance with applicable medical and/or professional standards
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes
- The most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient)
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost)
- Not Experimental/Investigational
- Not primarily for you, your families, or your Provider's convenience
- Not otherwise subject to an exclusion under this Certificate

The fact that a Physician and/or Provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary.

**Medicare** - a federally funded health insurance program that provides benefits for people age 65 and older. Some individuals under age 65 who are disabled or who have end stage kidney disease also are eligible for Medicare benefits.

**Member** - the Subscriber or any Dependent who is enrolled for coverage under this Certificate. Also referred to in this Certificate as "you" or "your". In some instances you or your child could also mean a surrogate decision-maker. We will accept the guidance of your surrogate decision-maker in those situations as required by state law.

**Mental Health Condition** - non-Biologically Based mental conditions that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (e.g., depression secondary to diabetes or primary depression). Mental Health is a condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical causes.

Services for Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) are covered as mental health conditions if provided by a licensed mental health Provider. In determining whether or not a particular condition is a Mental Health Condition, We may refer to the most current edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, or the International Classification of Diseases (ICD) Manual.

**Myotherapy** - the physical diagnosis, treatment and pain management of conditions which cause pain in muscles and bones.

**Nephritis** - infection or inflammation of the kidney.

**Nephrosis** - condition in which there are degenerative changes in the kidneys without the occurrence of inflammation.

**Non-participating Provider** - a Provider defined as one of the following:

- A Facility Provider, such as a Hospital, that has not entered into an agreement with Us;
- A Professional Provider, such as a Physician, who has not entered in to an agreement with Us;
- Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Certificate.

**Non-PPO Provider** - a Facility Provider or a Professional Provider that has entered into an agreement with Us or another Blue Cross and Blue Shield Plan to bill Us directly for Covered Services, and to accept Our Maximum Benefit Allowance as the maximum amount of payment for Covered Services, or a Non-Participating Provider who has not entered into an agreement with Us.

**Occupational Therapy** - the use of educational and rehabilitative techniques to improve your functional ability to live independently. Occupational Therapy requires that a properly accredited occupational therapist (OT) or certified Occupational Therapy assistant (COTA) perform such therapy.

**Open Enrollment** - the 31 days before to a group's Anniversary Date. During this period, you may enroll yourself and your Dependents for coverage or change coverage options, if this option is available.

**Orthopedic Appliance** - a rigid or semi-rigid support used to eliminate, restrict or support motion in a part of the body that is diseased, injured, weak or malformed.

**Orthotic** - a support or brace for weak or ineffective joints or muscles.

**Out-of-Network** - a term for Providers or facilities that do not enter into a network agreement with Us. Services received from an Out-of-Network Provider, usually result in a higher out-of-pocket expense to you than services rendered by an In-Network Provider.

**Out-of-Pocket Annual Maximum** - the Cost Sharing total that you may be responsible for under this Certificate for medical expenses under your policy during a specified period. The Out-of-Pocket Annual Maximum is designed to protect you from catastrophic health care expenses. For your Benefit Period, after the Out-of-Pocket Annual Maximum is reached, for most services, payment will be made at 100 percent of the allowable charge for the remainder of your Benefit Period. Benefit Period Maximums, Lifetime Maximums or maximum dollar limitations under this Certificate will still apply, even if you have satisfied your Out-of-Pocket Annual Maximum.

**Outpatient Medical Care** - non-surgical services provided in a Provider's office, the outpatient department of a Hospital or other facility, or your home.

**Paraprofessional** - a trained colleague who assists a professional person, such as a radiology technician.

**Participating Provider** - a Facility Provider (such as a Hospital) or a Professional Provider (such as a Physician) that has entered into an agreement with Us or another Blue Cross and Blue Shield Plan to bill Us directly for Covered Services, and to accept Our Maximum Benefit Allowance as the maximum amount of payment for Covered Services the Participating Provider must bill you for or use to calculate Cost Sharing amounts for Covered Services.

**Physical and Medical Rehabilitation** - care that includes a minimum of three hours of therapy, e.g., Speech Therapy, respiratory therapy, Occupational Therapy and/or Physical Therapy, and often some weekend therapy. Inpatient Medical Rehabilitation is generally provided in a rehabilitation section of a Hospital or a freestanding facility. Some skilled nursing facilities have "rehabilitation" beds.

**Physical Therapy** - the use of physical agents to treat disability resulting from disease or injury. Physical agents used include heat, cold, electrical currents, Ultrasound, ultraviolet radiation, massage and therapeutic exercise. Physical Therapy must be performed by a Physician or registered physical therapist.

**Physician** - A doctor of medicine or osteopathy who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided.

**PPO Provider** - a Participating Facility Provider or a participating Professional Provider that has entered into an additional agreement with Us, to limit charges for services performed under this Certificate.

**Preauthorization** - a process during which requests for services are reviewed, before services are rendered for approval of benefits, length of stay and appropriate location.

**Premium** - monthly charges that you and/or your group must pay to establish and maintain coverage.

**Prescription Drugs** - Prescription Drugs include:

**Brand name prescription drug** - the initial version of a medication developed by a pharmaceutical manufacturer or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires and FDA requirements are met, any manufacturer may produce the drug and sell the drug under its own brand name or under the drug's chemical (generic) name.

**Formulary** - a list of pharmaceutical products developed in Consultation with Physicians and pharmacists and approved for their quality and cost-effectiveness.

**Generic Drug** - medications determined by the FDA to be bio-equivalent to brand name drugs and that are not manufactured or marketed under a registered trade name or trademark. Normally, it is available only after the patent protection expires on a brand-name drug. A generic drug's active ingredients duplicate those of a brand name drug but may look different than the corresponding brand product. Generic drugs must meet the same FDA specifications as brand name drugs for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the counterpart brand name drug. On average, generic drugs cost less than the counterpart brand name drug.

**Legend Drug** - a medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law prohibits dispensing without a prescription." Compounded medications that contain at least one such medicinal substance are considered to be prescription legend drugs. Insulin is considered a prescription legend drug under this Certificate.

**Multi-Source Drug** - a Brand-Name Prescription Drug available from one manufacturer but there is at least one other equivalent (same active ingredients) generic drug available.

**Pharmacy** - an establishment licensed to dispense prescription drugs and other medications through a licensed pharmacist upon an authorized health care professional's order. A pharmacy may be an In-Network Provider or an Out-of-Network Provider. An In-Network pharmacy is contracted as an In-Network pharmacy with Us to provide covered drugs to you under the terms and conditions of this Certificate. An Out-of-Network pharmacy is **not** contracted with Us and services are not covered.

**Preauthorization** - the process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the pharmacy and therapeutics committee.

**Single Source Drug** - a Brand-Name Prescription Drug available from one manufacturer with no generic equivalents.

**Preventive Care** - comprehensive care that emphasizes prevention, early detection and early treatment of conditions through routine physical exams, immunizations and health education.

**Pre-Existing Condition** - any condition (mental or physical) regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six month period immediately preceding the date of your enrollment, or if earlier the first date of the waiting period for such enrollment.

**Private-duty nursing services** - services that require the training, judgment and technical skills of an actively practicing registered nurse (R.N.) or licensed practical nurse (L.P.N.). Such services must be prescribed by the attending Physician for the continuous medical treatment of the condition.

**Prosthesis** - a device that replaces all or part of a missing body part.

**Prostate screening** - testing to identify an increased risk of prostate cancer in the absence of any abnormal symptoms.

**Provider** - a person or facility that is recognized by Us as a health care Provider and fits one or more of the following descriptions:

**Professional Provider** — a Physician or other Professional Provider who is licensed or otherwise authorized by the state or jurisdiction where services are provided to perform designated health care services. For benefits to be payable, services of a Provider must be within the scope of the authority granted by the license and covered by this Certificate. Such services are subject to review by a medical authority appointed by Us. Other professional Providers include, among others, certified nurse midwives, dentists, optometrists, ophthalmologists, certified registered nurse anesthetists, chiropractors, massage therapists and registered dietitian. Services of such a Provider must be among those covered by this Certificate and are subject to review by a medical authority We appoint.

**Facility Provider** - an Inpatient and Outpatient Facility Providers as defined below:

- An Inpatient Facility Provider - is a Hospital, Alcoholism Treatment Center, residential treatment center, Hospice Facility, Skilled Nursing Care facility, Alternative Care facility or other facility which We recognize as a health care Provider. These Facility Providers may be referred to collectively as a Facility Provider.

- An Outpatient Facility Provider - is a dialysis center, Veteran's Administration or Department of Defense Hospital, Home Health Agency, Alternative Care Facility or other Facility Provider such as an Ambulatory Surgery Center (but not a Hospital, Alcoholism Treatment Center, Hospice Facility, Skilled Nursing Care facility or residential treatment center) recognized by Us and licensed or certified to perform designated health care services by the state or jurisdiction where services are provided. Services of such a Provider must be among those covered by this Certificate and are subject to review by a medical authority appointed by Us.

**Radiation Therapy** - x-ray, radon, cobalt, betatron, telocobalt, radioactive isotope treatment and similar treatments for malignant diseases and other medical conditions.

**Reconstructive Breast Surgery** - a surgical procedure performed following a mastectomy on one or both breasts to re-establish symmetry between the two breasts. The term includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastoplasty.

**Reconstructive Surgery** - in this Certificate reconstructive surgery includes those procedures that are intended to address a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect.

**Recovery** – Recovery is money the Member, the Member's legal representative, or beneficiary receives whether by settlement, verdict, judgment, order or by some other monetary award or determination, from another, their insurer, or from any uninsured motorist, underinsured motorist, medical payments, no-fault, personal injury protection, or any other insurance coverage, as a result of injury or illness to the Member. Regardless of how the Member, the Member's legal representative, or beneficiary or any agreement may characterize the money received, it shall be subject to the **THIRD PARTY LIABILITY: SUBROGATION AND RIGHT OF RECOVERY** provisions of this Certificate.

**Registered Dietitian** - a Registered Dietitian (RD) is a health care professional educated in nutrition and foods who is able to translate scientific information into appropriate food choices.

**Retail Pharmacy** - an establishment licensed to dispense Prescription Drugs by a licensed pharmacist upon a licensed health care professional's order.

**Room Expenses** - expenses that include the cost of the room, general nursing services and meal services for you.

**Second Opinion** - a visit to another Professional Provider (following a first visit with a different Provider) for review of the first Provider's opinion of proposed Surgery or treatment.

**Second Surgical Opinion** - a mechanism used by Managed Care organizations to reduce unnecessary Surgery by encouraging individuals to seek a Second Opinion before specific elective surgeries. In some cases, the health coverage may require a Second Opinion before a specific elective Surgery.

**Self-Administered Specialty Drug List** - a list of Specialty Pharmacy Drugs as determined by HMO Colorado which must be obtained from Our In-Network Specialty Pharmacy affiliate and which are billed under the pharmacy benefit.

**Skilled Nursing Care Facility (SNF)** - an institution that provides you with skilled nursing care, e.g., therapies and protective supervision if you have an uncontrolled, unstable or chronic condition. Skilled nursing care is provided under medical supervision to carry out nonsurgical treatment of chronic diseases or convalescent stages of acute diseases or injuries. Skilled nursing facilities do not provide you with care for high intensity medical needs, or if you are medically unstable.

**Special Care Units** - special areas of a Hospital with highly skilled personnel and special equipment to provide Acute Care, with constant treatment and observation.

**Specialty Pharmacy** - a pharmacy that is designated by Anthem, other than a Retail Pharmacy, mail-order, or other specialty pharmacy that provides high cost, biotech drugs which are usually injected, oral, infused or inhaled and used for the treatment of acute or chronic diseases.

**Specialty Pharmacy Drugs** - these are high-cost, injectable, infused, oral or inhaled medications as listed on the Medical Provider Administered Drug List and the Self-Administered Specialty Drug List that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at a Retail Pharmacy.

**Speech Therapy (also called Speech Pathology)** - services used for the diagnosis and treatment of speech and language disorders. A licensed and accredited speech/language pathologist must perform Speech Therapy.

**Spouse** - a Subscriber's legal Spouse.

**Stabilize** - the provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- Your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- Your transfer from an emergency department or other care setting to another facility; or
- Your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

**Step Therapy** - process of first requiring the use of designated medication over others for treatment as supported by clinical practice guidelines.

**Sub-Acute Rehabilitation** - inpatient rehabilitation therapy that has a duration in-between acute (short-term) and chronic (long-term) and includes a minimum of one hour of rehabilitation therapy per day. **Error! Bookmark not defined.**

**Subcontractor** – We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs, mental health, Alcohol and Substance Dependency services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer services duties on Our behalf.

**Subscriber** - the Member in whose name the membership with Us is established.

**Substance Dependency** - means alcoholism, drug and other substance abuse. Alcoholism, and substance abuse are conditions brought about when an individual uses alcohol, drugs or other substances in such a manner that his or her health is impaired and/or ability to control actions is lost.

**Surgery** - any variety of technical procedures for treatment or diagnosis of anatomical disease or injury, including, but not limited to cutting, micro Surgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, and other invasive procedures. Covered surgical services also include usual and related Anesthesia and pre- and post-operative care, including recasting.

**Surgical Assistant** - an assistant to the primary surgeon who provides required surgical services during a covered surgical procedure. We, at it's sole discretion, determine which surgeries do or do not require a Surgical Assistant.

**Therapy Services** - treatments or the application of remedies for diseases, conditions or injuries.

**Ultrasound** - a radiology imaging technique that uses high frequency sound waves to obtain a visual image of internal body organs or the fetus in a pregnant woman.

**Urgent Care** -an unexpected episode of illness or an injury requiring treatment that cannot reasonably be postponed for regularly scheduled care but which is not considered an emergency.

**Urgent Care Center** - an office or facility where care is provided for individuals who require immediate medical attention but whose condition is not life-threatening (non-Emergency).

**Utilization Management** - a process of integrating review of medical services and Care Management in a cooperative effort with other parties, including patients, Physicians, and other health care Providers and payers.

**Utilization Review** - a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or settings. Techniques include ambulatory review, prospective review, Second Opinion, certification, concurrent review, Care Management, Discharge Planning and/or retrospective review. Utilization Review also includes reviews to determine coverage. This is based on whether or not a procedure or treatment is considered Experimental/Investigational in a given circumstance (except if it is a specifically excluded under this Certificate), and review of your medical circumstances when such a review is necessary to determine if an exclusion applies in a given situation.

**Well-Child Visit** - a Physician visit that includes the following components: an age-appropriate physical exam, history, anticipatory guidance, and education (e.g., examining family functioning and dynamics, injury prevention counseling, discussing dietary issues, reviewing age-appropriate behaviors, etc.), and assessment of growth and development. For older children, a Well-Child Visit also includes safety and health education counseling.

**X-ray and Radiology Services** - services including the use of radiology, nuclear medicine and Ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

## Part 2: Anthem Blue Cross and Blue Shield

### *Vision Certificate*

#### Introduction

This certificate is a summary of the provisions of the vision insurance provided for Anthem members insured under the Community Colleges plan.

This certificate is attached as Part 2 of the health plan certificate issued to the individual subscriber. This certificate also insures the subscriber's eligible dependents if they are covered under the health plan.

All provisions of Part 1 of the health plan certificate are used to determine whether services are covered under this Part 2 of the health plan certificate.

#### Services and Benefits

If your care is rendered by a Network Provider, benefits will be provided at the Network level. Refer to the Health Benefit Plan Description Form. No benefits will be provided for care that is a Covered Service even if performed by a Network Provider.

We may inform you that it is not Medically Necessary for you to receive services. This decision is made upon review of your condition and treatment. We have final authority to determine the Medical Necessity of the service. You may appeal this decision. See Complaint Procedure in the How to File Claims in Appeals section of this Certificate.

**Network Providers** are Professional Providers and other facility Providers who contract with us to perform services for you. You will not be required to file any claims for services you obtain directly from Network Providers.

#### Non-Network Services

Services that are not obtained from a Network Provider will be considered a Non-Network Service. In addition, certain services may not be covered unless obtained from a Network Provider, and/or may result in higher cost-share amounts. See your Health Benefit Plan Description Form. You will be required to file claims for covered services you obtain directly from a Non-Network Provider.

#### Relationship of Parties (Plan - Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Provider or in any Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or cost sharing relationships related to provision of services or referrals to other Providers, including Network and Non-Network Providers. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or us.

## Not Liable for Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Certificate does not give anyone any claim, right, or cause of action against the Plan based on what a Provider of vision care, services or supplies, does or does not do.

## Definitions

This section defines certain words used throughout the Certificate. The first letter of each of these words will be capitalized whenever it is used as defined below in this text. Reading this section will help you understand the rest of the Certificate. You may also want to refer back to this section to find out exactly how — for the purposes of this Certificate — a word is used.

**Anthem Blue Cross and Blue Shield (Plan)** — Means Rocky Mountain Hospital and Medical Service, Inc., a Colorado insurance company doing business as Anthem Blue Cross and Blue Shield (also referred to as Anthem BCBS).

NOTE: “We,” “our,” and “us” refer to Anthem Blue Cross and Blue Shield or Anthem BCBS.

**Benefit Year** – Your Benefit Year begins on your effective date, and expires on the following June 30; a new Benefit Year commences on each subsequent July 1.

**Certificate (Membership Certificate)** — This document, which explains the benefits, limitations, exclusions, terms, and conditions of your health coverage.

**Copayment** - A specific dollar amount or percentage of the Maximum Allowable Amount for Covered Services indicated in the Health Benefit Plan Description Form for which you are responsible.

**Covered Services** - Services and supplies or treatment as described in the Certificate. To be considered Covered Services, services must be:

- Medically Necessary or otherwise specifically included as a benefit under this Certificate
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Certificate is in force;
- Not experimental or investigational or otherwise excluded or limited by the Certificate, or by any amendment or rider thereto.
- Authorized in advance by Anthem if such preauthorization is required in the Certificate.

A Covered Service is incurred on the date the service, supply or treatment was provided to you.

**Deductible** - The dollar amount of Covered Services listed in the Health Benefit Plan Description Form for which you are responsible before we start to pay for Covered Services each Benefit Year.

**Dependent** — For dependent eligibility see Part 1 of your health certificate.

**Effective Date** - The date when your coverage begins under this Certificate. A Dependent's coverage begins on the Effective Date of the sponsoring Subscriber.

**Elective Contact Lenses** - All contact lenses that are not Medically Necessary Contact Lenses.

**Eligible Person** - A person who satisfies the Group's eligibility requirements and is entitled to apply to be a Subscriber.

**Family Coverage** - A membership that covers two or more persons (the Subscriber and one or more Dependents).

**Group** - The employer that has entered into a Master Contract with the Plan.

**Individual Membership** — A membership covering one person (the Subscriber).

**Master Contract** — The agreement between us and your employer stating all of the terms and provisions applicable to your group coverage. The Master Contract governs the final interpretation of any specific provision contained in this Certificate.

**Maximum Allowable Amount** - The amount that we determine is the maximum amount payable for Covered Services you receive based on the established fee schedule. The Maximum Allowable Amount is subject to any Copayments, limitations or Exclusions listed in this Certificate.

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount. We will reimburse up to the Non-Par Reimbursement schedule identified in the Summary Plan Description.

For a Non-Network Provider who is a physician or other non-facility Provider, even if the Provider has a participation agreement with us for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for this Product.

The Maximum Allowable Amount is reduced by any penalties for which a Provider is responsible as a result of its agreement with us.

**Medically Necessary or Medical Necessity** - Services or supplies received for the treatment of an illness or injury or other health condition that is determined by us to be:

- Appropriate and consistent with the diagnosis or symptoms, and consistent with accepted standards of practice;
- Not experimental/investigative or unproven;
- Not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment; and
- Not provided only as a convenience to you, your physician, or another Provider or person.

The fact that any particular Provider may prescribe, order, recommend, or approve a service, supply, or level of care does not, of itself, make such treatment Medically Necessary. We have the final authority for determining the Medical Necessity of Covered Services.

**Member** - A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your."

**Network Provider** - A Provider who has entered into a contractual agreement or is otherwise engaged by us, or with another organization which has an agreement with us, to provide Covered Services and certain administration functions for the Network associated with this Certificate.

**Non-Network Provider** - A Provider who has not entered into a contractual agreement with us for the Network associated with this Certificate. Providers who have not contracted or affiliated with our designated Subcontractor(s) for the services they perform under this Certificate are also considered Non-Network Providers.

**Ophthalmology** —a branch of medical science dealing with the structure, function, and diseases of the eye. An ophthalmologist must be licensed to practice ophthalmology.

**Optometry** — an examination of the eye for defects or faults in refraction and the prescribing of correctional lenses or exercises. An optometrist must be licensed to practice optometry.

**Premium** - The periodic charges which the Member or the Group must pay the Plan to maintain coverage.

**Provider** - A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that we approve. This includes any Provider rendering services, which are required by applicable state law to be covered when rendered by such Provider.

**Subcontractor** - Anthem may subcontract particular services to organizations or entities that have specialized expertise in certain areas. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on our behalf.

**Subscriber** - An eligible employee or member of the Group who is eligible to receive benefits under the Master Contract.

## Membership Eligibility, Enrollment, Changes, and Termination

For eligibility information see Part 1 of your health certificate.

### When Coverage Under This Vision Certificate Ends

If your group is covered by provisions requiring continuation of group coverage under Colorado or Federal Law (Consolidated Omnibus Budget Reconciliation Act of 1985 COBRA), you and your covered Dependents who lose eligibility under a group may be able to continue as group Members for a limited period of time. Contact your group for information. **Note: COBRA does not apply for vision if the group or member is not enrolled in a health coverage through Anthem Blue Cross and Blue Shield.**

If you are voluntarily removing a Dependent, the deletion will be effective the next service date following receipt of the membership change form.

If a Member does not elect or does not qualify for Colorado or COBRA continuation, coverage under this Certificate ends on the earliest of the following dates:

For any Member, including Dependents:

- When the Subscriber's employer gives us written notice of termination. If the employer fails to timely remove an ineligible Member, we reserve the right to recoup any benefit Payments made on behalf of such person. Coverage will be terminated on the next monthly service date.
- Upon the Subscriber's death.

NOTE: Surviving eligible Dependents remain covered through the last paid billing period. Surviving Dependents have the right to select Colorado or COBRA continuation coverage for himself/herself.

- When we do not receive the premium payment on time.
- When there is fraud or intentional misrepresentation of material fact on the part of the Member.
- When Medicare becomes the Member's primary coverage unless the Member is in a group with fewer than 20 employees. See **Medicare Eligible Members** in this section for additional information.
- When the Member is no longer eligible for this group coverage under the terms of the Master Contract.
- The date group coverage under this Certificate is discontinued for the entire group, or the employee's enrollment classification.

For a Dependent:

- When the Dependent child marries, such a dependent has the right to select Colorado or COBRA continuation.
- At the end of the last paid billing period for Dependent coverage.
- When the Dependent no longer qualifies as a Dependent by definition, such a dependent has the right to select Colorado or COBRA continuation.
- The date of a final divorce decree or legal separation for a Dependent spouse, such a dependent has the right to select Colorado or COBRA continuation.
- When the Subscriber notifies us in writing to end coverage for a Dependent.

We will not refund membership premium paid in advance on behalf of the deleted Member if:

- We do not receive the membership change form within 31 days of the effective date of change.
- We have paid any claims on behalf of the deleted Member.

Colorado or COBRA continuation coverage ends:

- When the Member becomes eligible or covered for all medical conditions under another group plan (as an employee or otherwise).
- **18, 29 or 36 months** after termination of coverage.
- The date on which an employee whose COBRA coverage was extended to 29 months is determined under the Social Security Act to no longer be disabled.

- When the Colorado or COBRA continuation period expires.

### **Grace Period**

The Master Contract has a 31-day Grace Period. This means that if any required Premium is not paid in full, on or before the date it is due, it may be paid during the following 31 days without interest charge. During such Period, the Master Contract stays in force.

### **Reinstatement**

If coverage under this Certificate lapses because the Premium has not been paid within the time allowed, you will not be reinstated automatically. Re-application may be necessary, unless termination resulted from inadvertent clerical error. Your coverage shall not be adversely affected due to the Group's clerical error. However, the Group is liable to us if we incur financial loss as a result of the Group's clerical error.

### **Conversion**

Conversion coverage is not available under this Certificate.

## What We Will Pay For — Benefits

This section describes the Covered Services available under your vision care benefits when provided and billed by Network Providers. All Covered Services are subject to the exclusions listed in the Exclusions section and all other conditions and limitations of the Certificate. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider and whether or not you choose optional services and/or custom materials rather than standard services and supplies. Payment amounts are specified in the Health Benefit Plan Description Form.

The following are Covered Services:

- Vision examination when performed by an ophthalmologist or optometrist.

Services obtained through a Non-Network Provider are subject to the same Exclusions and limitations as services through a Network Provider.

## What We Will Not Pay For — General Limitations and Exclusions

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining benefits of services or supplies.

We do not provide vision benefits for services, supplies or charges:

- Received from an individual or entity that is not a Provider, as defined in this Certificate.
- Which are experimental or investigative or related to such, whether incurred prior to, in connection with, or subsequent to the experimental or investigative service or supply, as determined by us.
- For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover benefits or compensation from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For illness or injury that occurs as a result of any act of war, declared or undeclared.
- For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- Received from a vision or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.
- Prescribed, ordered, or referred by, or received from a member of your immediate family, including your spouse, child, brother, sister, or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except, as specified elsewhere in this Certificate or as otherwise prohibited by federal law.
- In excess of Maximum Allowable Amount.
- Incurred prior to your Effective Date.
- Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
- For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a Group, mutual benefit association, labor union, trust, or similar person or group (unless received by a Network provider).

- For any new FDA approved drug product or technology (including but not limited to medications, medical supplies, and/or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to pharmacies, for the first 6 months after the date the product or technology received FDA new drug approval or other applicable FDA approval. The Plan may, in its sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology.
- For sunglasses and accompanying frames.
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For non-prescription lenses.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Member has reached his or her normal interval for service when seeking replacements.
- For services or supplies not specifically listed in the Certificate.
- Low Vision
- Cosmetic Options
  - Blended lenses
  - Contact lenses (except as noted herein)
  - Oversize lenses
  - Progressive multifocal lenses
  - Photochromatic lenses or tinted lenses
  - Frames that exceed the Maximum Allowable Amount
  - Cosmetic lenses
  - Optional cosmetic processes
  - UV-protected lenses

## **GENERAL PROVISIONS**

### **Administration**

Note: The following provision only applies where the interpretation of this Certificate is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

The Plan, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of this Certificate. This includes, without limitation, the power to construe the Contract and Certificate, to determine all questions arising under this Certificate, and to make, establish and amend the rules and regulations and procedures with regard to the interpretation and administration of the provisions of this Certificate. However, these powers shall be exercised in such a manner that has a reasonable relationship to the provisions of the Contract and Certificate. A specific limitation or Exclusion will override more general benefit language.

### **Anthem Insurance Companies, Inc.**

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Certificate constitutes a contract solely between the Group and Anthem Insurance Companies, Inc. (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the State of Colorado. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

### **Circumstances Beyond the Control of the Plan**

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the Plan, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of vision care services provided under this Certificate is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render services provided under this Certificate insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

### **Clerical Error**

Clerical error, whether of the Group or the Plan, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

### **Conformity with State Law**

Any provision of this Plan, which is in conflict with the laws of the state in which it is issued, is hereby amended to conform with the minimum requirements of such laws.

### **Coordination of Benefits**

We consider this Plan primary in all circumstances.

## **Disclaimer of Liability**

We have no control over any diagnosis, treatment, care, or other service provided to a Member by any Provider, and we are not liable for any loss or injury caused by any health care Provider by reason of negligence or otherwise.

## **Entire Contract**

This Certificate, the Master Contract, the Group application, any Riders, Endorsements or Attachments, and the individual applications of the Subscriber and Dependents, if any, constitute the entire Contract between the Plan and the Group and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by the Group and any and all statements made to the Group by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Certificate, shall be used in defense to a claim under this Certificate.

## **Execution of Papers**

On behalf of yourself and your Dependents you must, upon request, execute and deliver to us any documents and papers necessary to carry out the provisions of this Certificate.

## **Form or Content of Certificate**

No agent or employee of the Plan or anyone acting on our behalf is authorized to change the form or content of this Certificate. Such changes can be made only through an endorsement authorized and signed by an officer of the Plan.

## **Interpretation of Certificate**

The laws and regulations of the State of Colorado, which issued the Certificate of Authority to the Plan, shall be applied to the interpretations of this Certificate.

## **Modifications**

By this Certificate, the Group makes the Plan coverage available to eligible Members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Master Contract, or by mutual agreement between the Plan and the Group without the consent or concurrence of any Member. By electing vision coverage under the Plan or accepting the Plan benefits, all Members legally capable of contracting and the legal representatives of all Members incapable of contracting agree to all terms, conditions, and provisions hereof.

## **Other Government Programs**

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

## **Payment in Error**

If we make an erroneous benefit Payment, we may require you, the Provider of services, or the ineligible person to refund the amount paid in error. We reserve the right to correct Payments made in error by

offsetting the amount Paid in error against new claims. We also reserve the right to take legal action to correct Payments made in error.

### **Pilot Programs**

We may occasionally develop pilot programs to test different benefits or recognize different Providers. The fact that a pilot program may exist does not guarantee that all Members are eligible for pilot program benefits or that such benefits will be permanent.

### **Plan's Sole Discretion**

The Plan or anyone acting on our behalf, may, at its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if it is determined such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

### **Policies and Procedures**

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Certificate with which a Member shall comply.

### **Relationship of Parties (Group-Member-Plan)**

Neither the Group nor any Member is the agent or representative of the Plan.

The Group is fiduciary agent of the Member. The Plan's notice to the Group will constitute effective notice to the Member. It is the Group's duty to notify the Plan of eligibility data in a timely manner. The Plan is not responsible for payment of Covered Services of Members if the Group fails to provide the Plan with timely notification of Member enrollments or termination's.

### **Right of Recovery**

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

### **Sending Notices**

All notices to the Subscriber are considered to be sent to and received by the Subscriber when deposited in the United States mail with postage prepaid and addressed to either:

- The Subscriber at the latest address appearing on our membership records; or
- The Subscriber's employer.
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### **Subscriber's Legal Expense Obligations**

You and your Dependents are liable for any actions that may prejudice our rights under this Certificate. If we must take legal action to uphold our rights and prevail in that action, we will be entitled to receive and you agree to pay our legal expenses, including attorney's fees and court costs.

## Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Certificate, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

## How To File Claims and Appeals

This section explains how to file claims to obtain benefits, and what to do if you disagree with the action taken on your claim.

### How to File Claims

When a Network Provider bills us for Covered Services, we will pay them the appropriate benefit directly. Payment is subject to any applicable Copayment requirements.

If a Non-Network Provider does not bill us directly, you must file your own claim. You must send us your receipt from the Provider and include your member number. Balance due statements, cash register receipts, and cancelled checks are not acceptable. All information on the receipt must be readable. If information is missing on your receipt or is not readable, it will be returned to you.

We are not required to honor an assignment of benefits to Non-Network Providers. We may honor an assignment of benefits to Non-Network Providers at our sole discretion. If we pay you directly, you will be responsible for paying the Non-Network Provider of services for all charges.

### Where and When to Send Your Claim

Make copies of the bills for your own records and attach the original bills to the receipt. Submit the receipt (including your member number) to:

Anthem Blue Cross and Blue Shield  
555 Middle Creek Parkway  
Colorado Springs, Colorado 80921

Your claim must be filed **within 365 days** after the date of service. Any claims filed after this limit may be refused. Failure to file a claim within such time shall not invalidate or reduce any claim if it is shown that it was not reasonably possible to give such notice and that notice was given as soon as reasonably possible.

Your claim will be processed in accordance with the time frame as required by State law for prompt payment of claims.

### Confidentiality and Disclosure of Information

This policy sets forth guidelines regarding a member's right to access and amend information in Anthem's possession. The policy specifically addresses when a release, signed by a Member, is required before information may be disclosed by us to parties such as a Member's Provider, spouse or other family Members. The policy includes the following key points:

- On the enrollment application, Subscribers sign a consent form to allow the release of any information or records concerning claims, conditions, or treatments of you, your Spouse, and/or your Dependents enrolled under the Plan for routine uses. Routine uses of Member information include but are not limited to: payment of claims, health care operations, plan administration, quality improvement, utilization review, Coordination of Benefits, audits, health promotion, disease management and prevention programs and other uses stated specifically in the enrollment application. By signing the application form, you also agreed and consented to the recording and/or monitoring of any telephone conversation between you and us.
- Members have the right to approve the release of information for non-routine uses of data. In certain circumstances, We may obtain a specific release form before information is disclosed.
- For members unable to give consent, We will obtain a copy of the guardianship papers or power of attorney before releasing confidential information to the Member's representative.
- Members have the right to access their medical records and to request that We restrict others access to their confidential information.
- We take reasonable precautions to protect Member information and maintain privacy in all settings. Our contracts with practitioners and providers explicitly state expectations about the confidentiality of Member information and records.

- We may provide certain information, upon request, to employers or their representatives without specific consent. In certain circumstances, We may request that you sign a specific release form before information is disclosed. If information is released, We advise the employer that it must be kept confidential to the extent necessary or as otherwise provided by law, and that it should not be used for unlawful purposes.

Also note that any person or entity having information about an illness or injury for which benefits are claimed may give us or anyone acting on our behalf any information about the illness or injury. We may provide any person or entity any information about an illness or injury upon its request, if it is providing similar benefits. Benefits will not be provided where sufficient information cannot be obtained to properly process a claim. You waive any and all privileges with respect to such information.

Our Customer Service Area may release information to you or your Spouse concerning a claim for benefits, or your coverage under this Certificate. If you do NOT want the Plan to release such information to anyone but yourself, you must notify us in writing. Your Spouse or any Dependent child over age 18 must also notify us in writing if they do not wish such information regarding their claims or coverage released to you by Customer Service.

The Member agrees to sign any papers and to provide Anthem Blue Cross and Blue Shield with any documents, papers, and information Anthem Blue Cross and Blue Shield may require to determine your rights under this Certificate and to determine the benefits on your claims.

## Plan Information Practices Notice

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

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

If you have a **complaint** about any aspect of our service or claims processing, please contact a Customer Service Representative at Anthem Blue Cross and Blue Shield at the phone number listed on your identification card. For purposes of this document, a **grievance** is a complaint about the quality of care or service received from a provider. You may also send a written complaint to the following address:

Anthem Blue Cross and Blue Shield  
Customer Service Department  
555 Middle Creek Parkway  
Colorado Springs, CO 80921

A trained representative will work to clear up any confusion and resolve your difficulties. Your written grievance will be investigated by our Quality Management Department. If you are not satisfied with the decision of Anthem Blue Cross and Blue Shield Customer Service, you may file an appeal as explained below.

## Appeals

Your appeal must be submitted in writing. While We encourage you to file appeals within 60 days of the adverse benefit determination, your written appeal must be received by Us within 180 days of the adverse benefit determination. Appeals may be for pre-service denials or post-service denials. We will assign a customer advocate to assist you in the appeal process. You must send written appeals to the following address:

Anthem Blue Cross and Blue Shield  
Appeals Department  
555 Middle Creek Parkway  
Colorado Springs, CO 80921

An appeal may be filed with or without first submitting a complaint. In the appeal, you must state plainly the reason(s) why the claim or requested service or supply should not have been denied. You should include any documents not originally submitted with the claim or request for the service or supply and any information that may have a bearing on our decision.

For a thorough, unbiased review, you may access two internal levels of appeal. In the case of a benefit denial based on utilization review, an independent external review appeal is also available to you. For pre-service denials based on utilization review, an expedited appeal and expedited independent external review may be available in certain circumstances.

You may designate a representative (e.g., your Physician or anyone else of your choosing) to file any level of appeal review with us on your behalf. You must give this designation to us in writing.

The Appeals process is governed by laws and regulations, and may be modified from time to time by Us as those laws may require. A more detailed description of the Appeals process and the decision timeframes is set forth in our appeals guide. This guide is available through our website or may be obtained free of charge by calling customer service.

## Legal Action

Before you take legal action on a claim decision:

- You must first follow the appeal process outlined above in **Complaints** and **Appeals**.
- You must meet all the requirements of this Membership Certificate.
- No action in law or in equity shall be brought to recover on this Certificate prior to expiration of 60 calendar days after written proof of loss has been filed in accordance with the requirements of this Certificate. No such action shall be brought at all unless brought within three years of the time within which written proof of loss has been filed as required by the Certificate.