052L-0715

A Guide to Your Benefits

You've made a good decision in choosing BlueAdvantage HMO

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products are underwritten by HMO Colorado, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

COLGHMONGF CO BA1 10-200 (Rev. 07/15)

Colorado Community College System
BlueAdvantage HMO Plan
Effective July 1, 2015

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Health maintenance organization (HMO)
2. OUT-OF-NETWORK CARE COVERED?[1]	Only for Emergency and Urgent 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 and copayment options reflect the amount the covered person will pay.

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4. DEDUCTIBLE TYPE[2]	Benefit Year
4a. ANNUAL DEDUCTIBLE[2a]	
a) Individual[2b]	No Deductible
b) Family[2c]	No Deductible
5. OUT-OF-POCKET ANNUAL MAXIMUM[3]	
a) Individual	$4,500 Copayments and Coinsurance are included in the Out-of-Pocket Annual Maximum.
b) Family	$9,000 Copayments and Coinsurance are included in the Out-of-Pocket Annual Maximum.
c) Is deductible included in the out-of- pocket maximum?	Not applicable Some Covered Services have a maximum number of days, visits or dollar amounts. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied.

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	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum for most Covered Services. Infertility diagnostic services have a lifetime maximum payment of $2,000 per Member. Bariatric surgery has a per occurrence maximum benefit of $15,000 per member for services received from a designated facility. Bariatric surgery has a per occurrence maximum benefit of $1,500 per member for services not received from a designated facility. Total per occurrence maximum benefit shall not exceed $15,000 per member.
7A. COVERED PROVIDERS	HMO Colorado managed care network. See Provider directory for complete list of current Providers.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes
8. MEDICAL OFFICE VISITS[4]	
a) Primary Care Providers	$30 Copayment per visit
b) Specialists	$50 Copayment per visit
9. PREVENTIVE CARE	
a) Children's services to age 13	No copayment (100% covered)
b) Adults' services	No copayment (100% covered) Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, contraceptives, immunizations and office visits.
10. MATERNITY	
a) Prenatal care	$50 Copayment for the first prenatal care office visit/delivery from the Doctor
b) Delivery & inpatient well baby care[5]	$700 Copayment per admission
11. PRESCRIPTION DRUGS **Level of coverage and restrictions on prescriptions[6]**	
a) Inpatient care	Included with the inpatient Hospital benefit (see line 12).
b) Outpatient care	**Retail Pharmacy Drugs** - Tier 1 $15 Copayment, tier 2 $50 Copayment, tier 3 $80 Copayment, tier 4 30% Copayment, per prescription at a participating pharmacy up to a 30-day supply. For tier 4 Retail Pharmacy drugs, the maximum Copayment per prescription is $100 per 30-day supply. Diabetic medication and supplies will be covered under the tier 1 $15 copayment. **Specialty Pharmacy Drugs** - Tier 1 $15 Copayment, tier 2 $50 Copayment, tier 3 $80 Copayment, tier 4 30% Copayment, per prescription from our Specialty Pharmacy up to a 30-day supply. For tier 4 Specialty Pharmacy Drugs the maximum Copayment per prescription is $100 per 30-day supply from our Specialty Pharmacy. Specialty Pharmacy Drugs are not available at a Retail Pharmacy or from a Home Delivery Pharmacy. Diabetic medication and supplies will be covered under the tier 1 $15 copayment.
c) Home Delivery Pharmacy Service	**Home Delivery Pharmacy Drugs** - Tier 1 $15 Copayment, tier 2 $100 Copayment, tier 3 $160 Copayment, tier 4 30% Copayment, per prescription through the Home Delivery Pharmacy up to a 90-day supply. For the tier 4 Home Delivery Pharmacy drugs, the maximum Copayment per prescription is $100 per 30-day supply or $200 per 90-day supply. Specialty Pharmacy Drugs are not available through the Home Delivery Pharmacy service. Diabetic medication and supplies will be covered under the tier 1 $15 copayment.

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
	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 costs. 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 Generic Copayment. The cost difference between the Generic and Brand Name Drug does not contribute the Out-of-Pocket Annual Maximum. By law, Generic and Brand Name drugs must meet the same standards for safety, strength, and effectiveness. We reserve the right, at our discretion, to remove certain higher cost Generic Drugs from this coverage. For drugs on our approved list, call Member service at 1-800-542-9402.
12. INPATIENT HOSPITAL	$700 Copayment per admission
13. OUTPATIENT / AMBULATORY SURGERY	$300 Copayment per Surgery at a free-standing non-hospital based facility $500 Copayment per Surgery at a hospital-based facility
14. DIAGNOSTICS **a) Laboratory & x-ray** **b) MRI, nuclear medicine, and other high-tech services**	 No Copayment (100% Covered) $100 Copayment per procedure for MRI/MRA/CT/PET scans at a free-standing non-hospital based facility $150 Copayment per procedure for MRI/MRA/CT/PET scans at a hospital based facility
15. EMERGENCY CARE[7,8]	$200 Copayment per Emergency room visit. Copayment is waived if admitted. Care is covered In or Out-of-Network.
16. AMBULANCE	$50 Copayment per trip for ground or air ambulance. Copayment is waived if admitted. Care is covered In or Out-of-Network.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$50 Copayment per urgent care visit. Urgent Care may be received from your PCP or from an Urgent Care Center. Care is covered In or Out-of-Network.
18. **MENTAL HEALTH CARE, ALCOHOL & SUBSTANCE ABUSE CARE** **a) Inpatient care** **b) Outpatient care**	 $700 Copayment per admission No copayment (100%) covered.
19. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY **a) Inpatient** **b) Outpatient**	 $700 Copayment per admission. Up to 30 inpatient rehab days per benefit year. $30 Copayment per visit for PCP $50 Copayment per visit for Specialist Up to 20 visits each for physical, occupational or speech therapy per benefit year. From birth until the Member's sixth birthday, benefits are provided as required by applicable law.
20. DURABLE MEDICAL EQUIPMENT & OXYGEN	No Copayment One wig following cancer treatment up to a $500 benefit maximum.
21. ORGAN TRANSPLANTS **a) Inpatient care** **b) Outpatient care**	 $700 Copayment per admission $30 Copayment per visit for PCP $50 Copayment per visit for Specialist Transportation and lodging services are limited to a maximum benefit of $10,000 per Transplant Benefit Period; unrelated donor searches are limited to a maximum benefit of $30,000 per Transplant Benefit Period.

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
22. HOME HEALTH CARE	No Copayment. Up to 100 visits per benefit year.
23. HOSPICE CARE	No Copayment
24. SKILLED NURSING FACILITY CARE	No Copayment covered. Up to 100 days per benefit year.
25. VISION CARE	Vision benefits can be found on the separate Anthem Vision Summary and Benefit Booklet
26. CHIROPRACTIC CARE	$30 Copayment per visit. Up to 20 visits per benefit year.
27. SIGNIFICANT ADDITIONAL COVERED SERVICES	**Retail Health Clinic** $30 Copayment per office visit. **Hearing Aids** 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. T**reatment of Autism Spectrum Disorders** Benefit level determined by type of service provided. The following annual maximums, based on benefit year, are effective for applied behavior analysis services: o From birth to age eight (up to Member's ninth birthday): 550 sessions of 25 minutes for each session o Age nine to age eighteen (up to Member's nineteenth birthday): 185 sessions of 25 minutes for each session **Osteopathic Manipulative Therapy** Osteopathic manipulative therapy (OMT) up to a maximum of 6 outpatient visits per benefit year.

PART C: LIMITATIONS AND EXCLUSIONS

28. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. [10]	Not applicable; Plan does not impose limitation periods for pre-existing conditions.
29. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
30. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable; Plan does not exclude coverage for pre-existing conditions.
31. 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
32. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No
33. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the Doctor who scheduled the procedure or hospital care is responsible for obtaining the Preauthorization.
34. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
35. What is the main customer service number?	1-800-542-9402
36. Whom do I write/call if I have a complaint or want to file a grievance?[11]	HMO Colorado, Complaints and Appeals 700 Broadway Denver, CO 80273 1-800-542-9402

37. 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
38. 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 #'s COLGHMONGF Group – Large
39. Does the plan have a binding arbitration clause?	Yes

[1] "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).

[2] "Deductible Type" indicates whether the deductible period is "Benefit 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".

[2a] "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 benefit 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.

[2b] "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.

[2c] "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.

[3] "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan.

[4] Medical office visits include physician, mid-level practitioner, and specialist visits.

[5] 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.

[6] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

[7] "Emergency care" means all services delivered in an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent layperson 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.

[8] Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

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 lives of the people We serve and the health of Our communities. 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 preventive care. Payment for the related office visit is based on the plan's preventive care provisions.

Mammogram Screenings

All plans provide coverage under the preventive care benefits for routine screening or diagnostic mammogram regardless of age. Payment for the mammogram screening benefit is based on the plan's provisions for preventive care.

Prostate Cancer Screenings

All plans provide coverage under the preventive care benefits for routine prostate cancer screening for men. Payment for the prostate cancer screening is based on the plan's provisions for preventive care.

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. Payment for preventive colorectal cancer screenings is based on the plan's provisions for preventive care.

The information above is only a summary of the benefits described. The Booklet includes important additional information about limitations, exclusions and covered benefits. The Schedule of Benefits (Who Pays What) section includes additional information about Copayments, Deductibles and Coinsurance. If you have any questions, please call our member services department at the phone number on the Schedule of Benefits form.

CONTACT US

Welcome to HMO Colorado, where it's Our mission to improve the health of the people We serve. You have enrolled in a quality health benefit plan that pays for many health care costs, including most costs for Doctor and outpatient care, Emergency care and Hospital inpatient care. Throughout this Booklet, "Our", "We" and "Us" refer to HMO Colorado.

This Booklet is a guide to your coverage. Please review this document to become familiar with your benefits, including what is not covered. By learning how coverage works, you can help make the best use of your benefits.

For questions about coverage, please visit Our website or call Our member services department. The website address is www.anthem.com and the toll-free member services number is located on the *Schedule of Benefits* section found in this Booklet or the Health Benefit ID card mailed to your home.

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

Mike Ramseier
President and General Manager
HMO Colorado

By accepting coverage under this Booklet, you accept its terms, conditions, limitations and exclusions. You are bound by the terms of this Booklet.

Health benefit coverage is defined in the following documents:

- This Booklet, the *Schedule of Benefits* and any amendments to it;
- The enrollment application and change form and any other application from you or your Dependents; and
- Your Health Benefit ID Card.

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

- The employer master application; and
- The Employer Master Contract between Us and your employer.

We, or someone on Our behalf, will determine how benefits will be managed and who is eligible under this Booklet. If any question comes up about any terms of this Booklet, or how they are applied, Our determination will be final. This may include questions of whether the services, care, treatment, or supplies are Medically Necessary, Experimental or Investigational, or Cosmetic. But you may use all applicable "Appeals and Complaints" procedures found in a section in this Booklet.

This Booklet is not a Medicare Supplement policy. If you are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Our member services.

Member Rights and Responsibilities

As a Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our In-Network Providers and the information you need to make the best decisions for your health and welfare.

You have the right to:

- Speak freely and privately with your Doctors and other health Providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect, and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
  - Our company and services.
  - Our network of Doctors and other health care Providers.
  - Your rights and responsibilities.
  - The rules of your health care plan.
  - The way your health plan works.
- Make a complaint or file an appeal about:
  - Your plan.
  - Any care you get.
  - Any Covered Service or benefit ruling that your plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your Doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a Doctor or other health care professional Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all plan rules and policies.
- Choose an In-Network Primary Care Provider, also called a PCP, if your health care plan requires it.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your Doctors or other health care Providers to make a treatment plan that you all agree on.
- Tell your Doctors or other health care Providers if you don't understand any type of care you're getting or what they want you to do as part of you care plan.
- Follow the care plan that you have agreed on with your Doctors or health care Providers.

- Give Us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our member service department know if you have any changes to your name, address or family members covered under your plan.

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

We value your feedback regarding the benefits and service provided under Our policies and your overall thoughts and concerns regarding Our operations. If you have any concerns regarding how your benefits were applied or any concerns about services you requested which were not covered under this Booklet, you are free to file a complaint or appeal as explained in this Booklet. If you have any concerns regarding a participating Provider or facility, you can file a grievance as explained in this Booklet. And if you have any concerns or suggestions on how we can improve Our overall operations and service, We encourage you to contact member service.

If you need more information or would like to contact Us, please go to www.anthem.com and select Customer Support > Contact Us. Or call the members services number on your Health Benefit ID Card.

How to Obtain Language Assistance

We are committed to communicating with Our Members about their health plan, no matter what their language. We use a language line interpretation service. Simply call the member services phone number on the back of your Health Benefit ID Card and a person will be able to assist you. Translation of written materials about your benefits can also be requested by calling member services.

Care Outside of Colorado

As an HMO Colorado Member, you have access to health care benefits across the country. To meet the different health care needs of Members who are away from home, HMO Colorado provides benefits for short trips and extended stays.

The Away From Home Care SM benefit is designed to bring you peace of mind if you are on vacation, have a dependent attending school in another state or have family members living in a different Service Area outside of Colorado.

Short Trips

If you are away from home for less than 90 consecutive days:

- For Emergency care, call 911 or go directly to the nearest Hospital. Notify Us within seventy-two hours of treatment or admission or as soon as reasonably possible.
- For non-Emergency care, call your PCP or Us for Preauthorization. The Preauthorization phone number is on the back of your health plan identification card.

Extended Stays

If you will be in a different Service Area outside of Colorado for at least 90 consecutive days, the Guest Membership benefits helps to ensure that you have ongoing access to your HMO Colorado health care benefits. To set-up your membership, follow these steps:

- Call Guest Membership toll free at 1-800-827-6422 for eligibility and specific location information. Guest Membership is not available in all areas.
- If a participating HMO (Host HMO) is in your destination area, Guest Membership will send you an application to complete, sign and return in an enclosed self-addressed envelope. Guest Membership will forward your completed application to the Host HMO. Please allow 20-30 calendar days for processing your application.
- The Host HMO will send you a health plan identification card, the name of your PCP (in some cases, you may be asked to choose a PCP), and information on how to use your Guest Membership.
- The Host HMO does not cover dental, vision, chiropractic care, massage therapy, acupuncture, nutritional counseling and substance abuse rehabilitation.
- Use your Health Benefit ID to access prescription benefits in the Host HMO area.

You won't have to complete a claim form or pay up front for your health care services, except for the out-of-pocket expenses (non-covered services and Copayments) you would normally pay.

Payments to the Host HMO may differ from those you would pay to HMO Colorado. Payment information will be included in your Guest Membership kit.

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ELIGIBILITY

Subscriber

The Subscriber is a Member in whose name the plan is issued.

If you are a new employee who works or resides in the Service area and you have a normal work week as noted in the Employer Master Contract, you can join the plan as a Subscriber. You can ask the employer for the number of hours you must work and other rules to be enrolled.

Dependents

Your Dependents may include the following:

- **Legal spouse,** the Subscriber's spouse, including the partner to a civil union as recognized by Colorado law. For information on spousal eligibility please contact the Group.
- **Common-law spouse**, all references to spouse in this Booklet include a common-law spouse.

  A common law spouse is an eligible Dependent who has a valid common-law marriage in Colorado. This is the same as any other marriage and can only end by death or divorce.
- **Designated beneficiary**. Your employer may have decided to offer benefits under this plan to designated beneficiaries. Check with your employer to learn more. If they are recognized by the employer, all references to spouse in this Booklet include a designated beneficiary. A Recorded Designated Beneficiary Agreement will need to be provided. A designated beneficiary is not eligible for COBRA under this Booklet.

  A designated beneficiary is an agreement entered into by two people for the purpose of making each a beneficiary of the other and which has been recorded with the county clerk and recorder in the county in which one of the person lives. The agreement is based on the Colorado Designated Beneficiary Act.
- **Same-sex (and, subject to Our Underwriting approval, opposite-sex) domestic partner**. Check with your employer to see if a domestic partner will be eligible. If domestic partners are recognized by the employer, all references to spouse in this Booklet include a domestic partner.

  Domestic partner means a person of the same sex (or opposite sex if approved by Underwriting) is the Subscriber's sole domestic partner; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.
- **Newborn child**. A newborn child born to you or your spouse is covered under your coverage for the first 31 days of birth. If the newborn is your grandchild, the newborn is usually **not** covered (see the Grandchild heading in this section).

  During the first 31 days after birth, a newborn child will be covered for Medically Necessary care. This includes well child care and treatment of medically diagnosed Congenital Defects and Birth Abnormalities. This is regardless of the limitations and exclusions applicable to other conditions or procedures of this Booklet. All services during the first 31 days are subject to Cost Sharing and any benefit maximums that apply to other conditions.

  To keep the child's coverage beyond the 31-day period, please send Us an Enrollment Application and Change Form to add the child if you have a non-family policy. We must get this form within 31 days after the birth of the child to continue coverage. You do not need to complete the form to add the child if you had family coverage at the time of birth of the child and if no additional Premium is required. Just provide Us notice within 60 days of the child's birth.
- **Adopted child**. An unmarried child (who has not reached 18 years of age) adopted while you or your spouse is enrolled will be covered for 31 days after the date of placement for adoption.

  "Placement for adoption" means when a Subscriber has a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement ends when the legal obligation for support ends.

  To keep the adopted child's coverage beyond the 31-day, you must send Us an Enrollment Application and Change Form to add the adopted child. We must get this form within 31 days after the placement of the child for adoption to continue coverage for the 32nd day and thereafter.
- **Dependent child**. A child (including a stepchild or a disabled child) under 26 years of age may be covered under the terms of this Booklet. Coverage stops at the end of the month in which the child turns 26. If you or your spouse have

a qualified medical child support order for this child, the Dependent child is eligible for coverage, up to age 26, whether the child lives with you or your spouse.

- **Disabled Dependent child**. An unmarried child of any age who is, medically certified as disabled, and dependent on the parent may be covered under the terms of this Booklet. The Dependent's disability must start before the end of the period they would become ineligible for coverage. We must be informed of the Dependent's eligibility for continuation of coverage within 31 days after the Dependent would normally become ineligible. You and the disabled Dependent's Doctor must send Us a Mentally or Physically Disabled Dependent Form. You may call Us or visit Our website to get such form.

- **Grandchild**. A grandchild of yours or your spouse is not eligible for coverage unless you or your spouse are the court-appointed permanent guardians or have adopted the grandchild. You must send an Enrollment Application and Change Form and proof of the court appointment or the legal adoption. One other option is to enroll the grandchild under an individual child-only plan with, subject to its terms and conditions.

Your group may have limited or excluded the eligibility of certain Dependent types and so not all Dependents listed in this Plan may be entitled to enroll. For more specific information, please see your Human Resources or Benefits Department.

Medicare-Eligible Members

Before you turn 65, or if you qualify for Medicare in other ways, you should contact the local Social Security Administration office to establish Medicare eligibility. You should then contact the employer to talk about options.

For details on how the benefits will be coordinated between Medicare and this plan, see the "General Policy Provisions" section.

Enrollment Process

This section lists who is eligible and what forms are needed for enrollment. Coverage starts on the Effective Date in Our files. No services before that date are covered.

Note: Sending an Enrollment Application and Change Form does not guarantee you get on the plan.

Enrollment Forms

You must send Us an Enrollment Application and Change Form to add any Dependents. More forms may be needed for special Dependent status. You can get such forms from your employer, Our member services or Our website.

Initial Enrollment

We must receive the enrollment form within 31 days after the date of hire or within 31 days of when the waiting period ends. The Effective Date will be determined by the waiting period. The employer can tell you the length of the waiting period.

Open Enrollment

Any eligible employee who did not enroll when they were first eligible can enroll during the employer's annual open enrollment period. This period is generally 31 days before the employer's Anniversary Date. The annual open enrollment period is subject to all provisions of the Booklet. The employer can tell you more about the open enrollment period.

Newly Eligible Dependent Enrollment

You 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. To add the Dependent, We must get an Enrollment Application and Change Form within 31, but no more than 60, days of the date of the event. Proof of the event, e.g., a copy of the marriage certificate or court order, must be attached to the form.

When you or your spouse are required by a court or administrative order to cover 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 you do not add the eligible Dependent within 31 days of the issuance of the order, you must wait until the next open enrollment to add the Dependent.

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the plan prior to open enrollment if they qualify for special enrollment. Except as noted otherwise below, the Subscriber or Dependent must request special enrollment within 31 days of a qualifying event.

Special enrollment is available for eligible individuals who:

- Lost coverage due to death of a covered employee;
- Due to termination or reduction in number of hours of the employee's employment;
- The covered employee becomes ineligible for benefits under Title XVIII of the Federal Social Security Act, as amended;
- Lost coverage under a health benefit plan due to the divorce or legal separation of the covered employee' spouse or partner in civil union;
- Is now eligible for coverage due to marriage (including a civil union where recognized in the state where the Subscriber resides), birth, adoption, placement for adoption;
- By entering into a Designated Beneficiary Agreement, if covered by the employer, or pursuant to a QMCSO or other court or administrative order mandating that the individual be covered;
- Termination of employment or eligibility for coverage, regardless of eligibility for COBRA or state continuation;
- Has a reduction in the number of hours of employment;
- Due to involuntary termination of coverage;
- Has a reduction or elimination of group contributions toward the cost of the prior health plan;
- Lost eligibility under the Colorado Medical Assistance;
- When the employee or dependent becomes eligible for premium assistance under the Colorado Medical Assistance Act of the Children's' Basic Health Plan; or
- A parent or legal guardian disenrolls a dependent, or a dependent becomes ineligible for the Children's Basic health Plan.

Important Notes about Special Enrollment:

- You must request coverage within 31 days of a qualifying event (i.e., marriage, birth of child etc.). For loss of coverage under the Colorado Medical Assistance Act, coverage must be requested within 60 days of the loss of coverage. For loss of coverage under the Children's Basic Health plan coverage must be requested within 90 days of the loss of coverage;
- Evidence of prior Creditable Coverage is required and must be furnished by you or your prior carrier.

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next open enrollment period.

Loss of State Medicaid Plan or State Child Health Insurance Program (SCHIP) - Loss of eligibility from a state Medicaid or SCHIP health plan is also a qualifying event for special enrollment for you or your Dependents. You must file an application with the employer within 60 days after coverage has ended. Also, special enrollment is allowed for the employee who becomes eligible for premium assistance, with respect to coverage under the employer's health coverage, under a state Medicaid or SCHIP health plan. This includes any waiver or demonstration project conducted under or in relation to these plans. Similarly, you must file an application with the employer within 60 days after the eligibility date for assistance is determined.

Late Entrants

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a special enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Military Service

Employees going into or coming back from military service can keep this coverage. This choice is required by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights apply only to employees and their Dependents covered under the plan before the employee leaves for military service:

- The longest period of coverage under this paragraph is the lesser of;
  - 24 months, starting on the date when the absence starts; or
  - The day after the person was required to, but failed to, apply for or return to work.
- A person who opts to keep this coverage may be asked to pay up to 102% of the Premium. But those on active duty for 30 days or less cannot be asked to pay more than the employee's share, if any, for the coverage.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Booklet to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

Multiple Coverage Plans with Us

You may have more than one group health plan with Us or any of Our affiliates. If you don't want both plans, you can cancel one of the plans and ask for a Premium refund. But to get a refund, you must tell Us within 31 days after the dual coverage starts. If We do not get notice within 31 days, you will not get a refund of past Premium. But you can still ask Us to cancel the plan you no longer want.

How to Change Coverage

If a group provides you with multiple health care options, you may switch to another coverage offered by the group during open enrollment.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

This is a Health Maintenance Organization (HMO) plan. We have coordinated and contracted with a network of Doctors, Hospitals, and support services (e.g., laboratory, x-ray, pharmacy, and physical therapy) to arrange for or provide total health care services to Members. Learning how an HMO works can help you make the best use of your health care benefits. The *Schedule of Benefits* lists out-of-pocket expenses and certain benefit limits you may incur. We strive to keep health care costs reasonable by working with you, your Doctor, Hospitals, and other Providers in unity. You and your Primary Care Provider (PCP) work together to obtain care from a Specialist and to obtain Preauthorizations for services . This helps to ensure that you receive care that is Medically Necessary, performed in the right setting, and is otherwise a Covered Service.

Primary Care Provider (PCP)

A key feature of an HMO is that one Provider will be primarily responsible for delivering and coordinating all of your care. That Provider is called a Primary Care Provider (PCP). PCPs are typically internal medicine Doctors, family practice Doctors, general practitioners, pediatricians, advanced nurse practitioner or advanced registered nurse practitioners. As your first point of contact, the PCP gives a wide range of health care services, including initial diagnosis and treatment, health supervision, management of chronic conditions, and preventive care. You can access care for In-Network Providers without a referral. As well, no authorization or referral is needed for an OB/GYN and certified nurse midwife care. Your PCP can provide you referrals and information about Specialists who are In-Network.

If We do not have an In-Network Provider for a Covered Service, We will arrange for an authorization to a Provider with the necessary expertise. We will also make sure that you receive the Covered Service at no greater cost than what you would have paid for such Covered Service if it had been received from an In-Network Provider.

Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service, even if Medically Necessary, performed by your PCP, or another In-Network Provider. If a service requires Preauthorization before it can be performed, your In-Network Provider is responsible for getting the Preauthorization.

Selecting A PCP

When you enroll, you must select a PCP. Family members are not required to choose the same PCP; they may select a PCP individually. For a covered child, you may also choose a pediatrician as the child's PCP. If a PCP is not chosen, We will assign one to you.

To locate a PCP go to Our directory of HMO Providers. The directory lists Doctors and Hospitals that are affiliated with each PCP. You can get a directory from your employer or from Us. You may also search for a Provider on-line at www.anthem.com You may call the member service number that is listed on your Health Benefit ID card or you may write Us and ask Us to send you a directory. Our listings include the credentials of Our physicians such as specialty designation and board certification.

Our website is continuously updated and is the most up-to-date list of Our PCPs. Some Doctors are listed as accepting existing patients only. However, We may not have notice of new limitations of this kind. Therefore, even if the listing for the PCP you select does not indicate patient limitations, you should call the PCP to make sure that the Provider is still accepting new patients (unless you are already an existing patient of the PCP).

When you visit an In-Network Provider an In-Network Provider will bill Us directly and accept Our Maximum Allowable Amount as payment in full. The Maximum Allowable Amount is the dollar amount approved by Us for a specific covered service.

Visiting A PCP

To visit a PCP, you must make an appointment with the PCP's office. The telephone number for the PCP can be found on your Health Benefit ID Card. To avoid possible delays when scheduling an office visit over the phone, you must identify yourself as an HMO Colorado Member.

You should notify your PCP's office at least 24 hours before a scheduled appointment if you need to cancel an appointment. You should check with your PCP to see how far in advance you must tell them of a cancellation. You may be charged a fee by your PCP's office for a missed appointment. We will not pay for such a fee. You should notify the PCP's office if you are going to be late for an appointment. The PCP may ask you to reschedule the appointment.

After hours care is provided by your Provider who may have a variety of ways of doing this. You should call your PCP for instructions on how to receive medical care after the PCP's normal business hours, on weekends and holidays, or to receive non-Emergency Care and non-Urgent Care within the Service Area for a condition that is not life threatening but that requires prompt medical attention. In case of an Emergency, you should call 911 or go directly to the nearest

Emergency room. If you are outside the Service Area, non-Emergency Covered Service may be covered. More information program can be found on the page entitled Care Outside of Colorado located in the front of this Booklet.

Changing PCPs

You may select a new PCP at any time (but no more than once per month) by requesting the change on an Enrollment Application/Change Form. You can also do this by visiting Our website or by calling Our member service department. However, you should call the PCP to confirm that the Provider is accepting new patients. A new Health Benefit ID Card will be sent to you confirming the PCP change.

The Effective Date of all PCP changes will be the first day of the month following the request. To have medical records sent from one PCP to another, you must contact your prior PCP. You are responsible for any fees related to transferring medical records.

If you change primary residence or place of employment to a location that is not convenient to your current PCP's office, you may choose a new PCP nearer to your new residence or place of employment. That new PCP needs to be within Our Service Area. You must notify Us within 31 days after a change in residence or place of employment by submitting an Enrollment Application/Change Form.

Care Outside of Colorado

When you are outside Our Service Area for extended periods of time, care is available through Guest Membership benefit. Details on the away from home care programs can be found in the front of this Booklet under Care Outside of Colorado.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) within a specific timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under this health benefit plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult a tax advisor.)

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your group to help you achieve your best health. These programs are not Covered Services under your plan, but are separate components, which are not guaranteed under your plan and could be discontinued at any time. If your group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by a different means. You may contact Us at the member service number on your Health Benefit ID Card and We will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Managed Care Features

Managed care is Our way of giving you access to quality, cost effective health care. It uses tools like utilization management and cost of services, and measures In-Network Provider and coverage performance. Your health benefit plan includes the processes of Preauthorization (except for OB/GYNs and certified nurse midwives), concurrent and retrospective reviews to determine when services should be covered by your health benefit plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your health benefit plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. This section of the Booklet explains how these managed care features are used and will guide you through the steps to get

care. For more information on what to do for Emergency care and Urgent Care, please see the "Benefits/Coverage (What Is Covered)" section.

We may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including Utilization Review, Care Management, and disease management) if in Our discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because We exempt a process, Provider or claim from the standards which otherwise would apply, it does not mean that We will do so in the future, or will do so in the future for any other Provider, claim or Member. We may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your Provider directory or contacting member services at the number on the back of your Health Benefit ID card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this benefit plan's members.

Our Process to Determine if Services are Covered

To decide if a health service is covered, We consider if the service is Medically Necessary or preventive and if the service is Experimental or Investigational or, Cosmetic. We also consider if the terms of this Booklet limit or deny benefits for the service. We use many resources, like:

- Peer-reviewed medical literature(such as publications and journals);
- Our adopted medical policies and practice guidelines;
- Guidelines or professional standards which We get from national organizations and professional groups; and
- Consultations with Doctors, Specialists and other health care professionals.

We will decide what services are covered under your Booklet and what services are not covered. But in making these decisions, We do not promote or reward Our employees or provider reviewers for withholding a benefit approval for Medically Necessary Covered Services that you are entitled to.

Medically Necessary - We decide whether services, procedures, supplies or visits are Medically Necessary. Other than preventive services, only Medically Necessary services, procedures, supplies or visits are eligible to be Covered Services. Our medical policy uses current standards of practice and evaluates medical equipment, treatment and interventions with an evidence-based review of scientific literature. As medical technology is often changing, We also create or update policies to address new medications, devices and procedures. We review and update Our medical, behavioral health and pharmaceutical polices on a regular basis. Those policies are considered part of this Booklet. In evaluating new technology and whether to consider it as eligible for coverage under Our policies, We consider peer-reviewed medical literature, consultations with Doctors, Specialists and other health care professionals, policies and procedures of government agencies and study results showing the impact of the new technology on long-term health.

Experimental or Investigational and/or Cosmetic Procedures - We don't pay for any services, procedures, surgeries or supplies that We consider Experimental or Investigational, and/or Cosmetic. In addition We don't pay for complications arising from any services, procedures, surgeries or supplies that We consider Experimental or Investigational, and/or Cosmetic.

Even if Medically Necessary and not Experimental or Investigational, and/or Cosmetic, a service might not be covered. The benefits, exclusions and limitations of your coverage take priority over medical policy.

Also, certain procedures, diagnostic tests, Durable Medical Equipment, home care services, home intravenous services and medications require Our Preauthorization to be covered. The current list of services requiring Preauthorization is on Our website. See the "Appropriate Place and Preauthorization" below for additional details.

Appropriate Place and Preauthorization

You can get care in an inpatient or outpatient setting. The setting depends on your health condition and what services are needed to manage your health. We cover care in both places if 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 setting are the Doctors' office, ambulatory Surgery center, Retail Health Clinic, Home Care and home Hospice settings. For human organ transplant services to be covered they need to be received from a Center of Excellence.

Preauthorization is a process We use to determine if a service or supply is a Covered Service and if your care is given in the right medical setting. The Preauthorization process may set limits on the coverage available under this Booklet. Preauthorization is required before a Hospital admission or before receiving certain procedures or services. Some drugs also require Preauthorization.

Preauthorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may determine that a service that was initially prescribed or requested is not Medically Necessary if you have not previously tried alternative treatments which are more cost effective.

The Provider who schedules an admission or orders the procedures or service is responsible for getting Preauthorization.

Inpatient Admissions - Inpatient admissions include admissions to acute care Facility Providers (Hospitals), long-term care Facility Providers, sub-acute Facility Providers, rehab Facility Providers, Skilled Nursing Care Facility Providers and inpatient Hospice Facility Providers. Admissions for all inpatient stays require Preauthorization. Also, once admitted, further care will be reviewed under Our concurrent review guidelines. 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 for the set number of days We have preauthorized If additional days are requested by the Provider, We will reevaluate Our Preauthorization . This helps with your timely discharge or transfer to the appropriate level of care.

Routine newborn care admissions usually do not require Preauthorization. But if the baby needs to stay in the Hospital after the mother leaves, Preauthorization is required for the baby's continued stay.

Scheduled Admissions - Your Provider should get Preauthorization from Us at least 15 days before a planned admission begins. Then, if the stay goes over the number of days on the Preauthorization, the Provider must get additional authorization. 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 - You don't need Preauthorization for an Emergency admission. But We do need to be contacted within seventy-two hours after the admission, unless you are unable to do so. If you can't notify Us within seventy-two hours, you still need to notify Us of the admission as soon as you can. We may deny your coverage if you do not tell Us within seventy-two hours. Some examples of Emergency admissions are admissions involving accidents, alcohol detoxification, or the onset of labor in pregnancy.

Outpatient Procedures - Even outpatient procedures may need Preauthorization. You and your Providers can visit Our website at www.anthem.com or call Our member services for a list of outpatient procedures and services that need Preauthorization. Your Provider must contact Us for Preauthorization. If preauthorized, these services may be performed in a Hospital on an outpatient basis or in a freestanding facility, such as an Ambulatory Surgery center.

Ambulance Services - Some Ambulance services may need Preauthorization. All scheduled ground Ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be preauthorized. All air Ambulance services for non-emergency Hospital to Hospital transfers, except transfers from one acute Facility to another, must be preauthorized.

Prescription Drugs - Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. For a list of drugs that need Preauthorization or a Prescription Drug Prior Authorization Request form, please call the phone number on your Health Benefit ID Card or check our website at www.anthem.com.

Urgent Prior Authorization - If the request is for urgently needed drugs, after We get the Prescription Drug Prior Authorization Request form:

- We will review the Urgent Prior Authorization Request and decide if We will approve or deny it within one business day of receiving the request. We will notify you, the prescribing Provider, and the dispensing pharmacy what We have decided.
- If more information is needed to make a decision, We will tell the prescribing Provider what information is needed within one business day of receiving the request.
- If the additional information requested from the prescribing Provider is not received within two business days of the prescribing Provider's receipt of the request, the request will be deemed denied. We will provide you, the

prescribing Provider, and the dispensing pharmacy with confirmation of the denial within one business day of the date the request was deemed denied.

- Once the requested additional information is received, We will make a decision in accordance with applicable law.

Note: If We do not request additional information or provide notification of approval or denial as required by applicable law, the request will be deemed approved. We will provide you, the prescribing Provider, and the dispensing pharmacy with confirmation of the approval within one business day of the date the request was deemed approved.

Non-Urgent Prior Authorization - If the request is for non-urgently needed drugs, after We get the Prescription Drug Prior Authorization Request form through Our electronic pre-authorization system:

- We will review the request and decide if We will approve or deny it within two business days of receiving the request. We will notify you, the prescribing Provider, and the dispensing pharmacy.
- If more information is needed to make a decision, We will tell the prescribing Provider what information is needed within two business days of receiving the request.
- If the additional information requested from the prescribing Provider is not received within two business days of the prescribing Provider's receipt of the request, the request will be deemed denied. We will provide you, the prescribing Provider, and the dispensing pharmacy with confirmation of the denial within two business days of the date the request was deemed denied.
- Once the requested additional information is received, We will make a decision in accordance with applicable law.

Note: We must provide notification of approval or denial to you, the prescribing Provider, and the dispensing pharmacy within three business days upon receipt of a non-urgent prior authorization request received via facsimile, electronic mail, or verbally with associated written confirmation.

If We do not request additional information or provide notification of approval or denial within:

- Two business days of the receipt of an electronically filed non-urgent prior authorization request, as required by applicable law, the request will be deemed approved. We will provide you, the prescribing Provider, and the dispensing pharmacy with confirmation of the approval within two business days of the date the request was deemed approved; or
- Three business days of the receipt of a non-urgent prior authorization request that has been submitted via facsimile, electronic mail, or verbally with associated written confirmation, as required by applicable law, the request will be deemed approved. We will provide you, the prescribing Provider, and the dispensing pharmacy with confirmation of the approval within two business days of the date the request was deemed approved.

Appropriate Length of Stay

We work with your Providers, use medical policies and medical care guidelines to decide how long your Hospital stay is covered. We also use concurrent review to decide how long your stay is covered.

Concurrent Review - While you are in the Hospital, We will review your medical care to see if you are getting appropriate and Medically Necessary Hospital services. We need to be told about the admission promptly to help with the management and authorization of any Covered Services during and after your Hospital stay.

At some point during an approved Hospital stay, We may decide that further days or care is not Medically Necessary. We will notify you, your attending Doctor and the Hospital of this decision. You can choose to stay in the Hospital after authorization ends, but We will not pay for services after the recommended date of discharge. **You will need to pay for all charges owed after the recommended day of discharge.** For more information, read about When We Deny Preauthorization below.

When We Need More Information

We may request more information from you or others to decide whether to preauthorize the procedure. After We have received all information and made a decision, We will confirm Our decision within two business days. If We don't get the information requested, the Preauthorization may be denied.

If a Preauthorization of a requested service meets Medical Necessity criteria, it **does not guarantee** that payment will be allowed. Fraud or abuse, or changes in eligibility afterwards, could cause a denial of payment. When We receive your claim(s), We will review them against the terms of this Booklet. Also, the Preauthorization is only good for a specific place

and period of time. Services which are not given in the place and time authorized may be denied. If additional services or time are needed, another or extended Preauthorization is required.

When We Deny Preauthorization

If We do **not** give you the Preauthorization, you may have to pay for all charges which were not preauthorized. But You or your representative can Appeal Our Preauthorization decision by following the procedure outlined in the "Appeals and Complaints" section.

Retrospective Claim Review

This is when We decide to review the care after it was given to you We may do so to see if the care that was given was what We preauthorized. Or it may be to check how much your care cost or how it matches up against available benefits, medical policy and medical necessity. We may ask to see your medical records to help Us decide what is covered. If We decide your care is not covered We will not pay for it. But you or your representative can appeal Our decision by following the procedure outlines in the "Appeals and Complaints" section.

Ongoing Care Needs

We coordinate ongoing care through services like transition of care, utilization management, care management and disease management.

Transition of Care

If you are getting ongoing care for a medical condition when you first enroll in this coverage, We may be able to help ease the transition. Examples of ongoing care are prenatal/obstetrical care, Home Care or Hospice care. We try to avoid disruption of a new Member's care through Our transition of care policy. If interested, 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 can get these materials by calling Our medical management department at 303-831-3238 or 1-800-797-7758.

Utilization Management

Utilization management is when We look at national guidelines and medical policies to decide if your care is medically needed, given in the right setting and for the right amount of time or visits. We may decide that some or all of a service is not covered. Despite Our decision about coverage, what care you choose is entirely between you and your Provider.

Care Management

You may have an illness or injury that is so complex that a care plan is needed. Some examples are Members with a spinal cord injury or in need of a transplant. Through this care management a care manager may work with you or your family to help coordinate medical care. The care manager may also help organize a smooth transition from Hospital care to home care. We designed this program to identify patients, early in their care, who may benefit from this service. Care management helps Providers document, assess and address the issues related to care. It also helps in getting care issues resolved consistently and on time. Bottom line, care management helps promote quality care results.

We decide who qualifies for care management. Not everyone with the same illness or injury may qualify for care management. It depends on how much care management We decide you need. We have nurses and other qualified staff to give care management when needed. They have been specially trained to coordinate care in complex cases. You may work one on one with a care manager. Then again you may not. It depends on whether there is a liaison at the place where you are admitted. If you are assigned a care manager, you will get the care manager's phone number. That way you can call the care manager with any questions you have.

Care managers handle a number of care-related tasks. They work with Providers, patients and patients' families to draw up a care plan. Then they help implement and monitor that plan. They also decide if you are getting what you need when you need it and in the place where you need to get it.

We fit care management to individual needs. We may offer benefits for some alternate care that is not listed as a Covered Service. We typically only do this in cases with intensive care management. Cases like these are rare. We may also extend Covered Services beyond the limits of coverage listed in this Booklet. We will make these decisions case-by-case. Just because We have extended benefits or approved alternate care one time does not mean We have to do it again for you or for any other Member. We may change or stop giving extended benefits or alternate care. When this happens We will notify you or your representative in writing.

Disease Management

This is when We help coordinate care for Members who have specific, persistent or chronic conditions like diabetes, heart disease and asthma.

These disease management programs are designed to promote self-management. It also encourages you to comply with your Provider's plan of care. Disease management stresses prevention, education and care coordination. These help to avoid acute episodes as well as the disease getting worse slowly. We base Our programs on the best practices and results found in peer-reviewed medical literature. We regularly send care reports to Providers. This promotes continuity of care.

We may not offer programs to everyone with the conditions listed above. Also, conditions that are more complicated may need more intense and more frequent services. Just because We have offered disease management to you does not mean We have to offer other programs to you or any other Member. It's also up to you.

Disease management is voluntary and you can choose to participate or stop at any time.

We have an agreement with Providers who participate in disease management programs. The agreement may include financial incentives or risk-sharing relationships. These relationships are related to the services provided or to referrals to other Providers. These other Providers include network Providers and disease management programs. You can contact your Provider or Us if you have questions about these incentives and 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 Doctors may refer their patients to Us. You may also call Us directly at Our Help Line (303) 764-7066 or (877) 225-2583. Additional information about Our disease management and wellness programs is available on Our website under the Blue*Cares* for You heading.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, We participate in a program called "BlueCard." This program lets you get Covered Services at the In-Network cost-share when you are traveling out of state and need Emergency or urgent care services as long as you use a BlueCard Provider. All you have to do is show your Health Benefit ID Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to Us.

If you are out of state and an Emergency or urgent situation arises, you should get care right away.

To find the nearest contracted Provider, you can visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Health Benefit ID Card.

Please note that you only have coverage for Emergency and urgent care services when using a BlueCard Provider. You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care Outside the United States - BlueCard® Worldwide

Before you travel outside the United States, check with your Group or call member services at the number on your Health Benefit ID Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and We suggest:

- Before you leave home, call the member services number on your Health Benefit ID Card for coverage details. Please note that you only have coverage for Emergency and urgent care services when traveling outside the United States.
- Always carry your up to date HMO Colorado Health Benefit ID Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.

- You need Inpatient care. After calling the Service Center, you must also call Us to get approval for benefits at the phone number on your Health Benefit ID Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Details

- **Participating BlueCard Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should send in your claim for you.

- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.

- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to Us.

Claim Forms

You can get international claim forms from Us, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

BENEFITS/COVERAGE (What is Covered)

This section describes your benefits. You must get care from In-Network Providers for your benefits to be covered. The exceptions to this are Emergency Care, Urgent Care or when preauthorized by Us. If you use an out-of-network Provider your services may be denied if services are not for an exception as indicated above. To learn more, read your *Schedule of Benefits*.

Covered Services and supplies are only covered if they are Medically Necessary or preventive. They are not covered if they are Experimental or Investigational, and/or Cosmetic. They are not covered if not preauthorized where required. All services must be standard medical practice where they are received for the health problem being treated, and they must be legal in the United States. The fact that a Provider may order, advise or approve that you receive a service, treatment or supply does not make it Medically Necessary or a Covered Service. It also does not promise payment by Us. To learn more, read the "How to Access Your Services and Obtain Approval of Benefits" section in this Booklet.

Services, supplies, tests and drugs are not covered if they are excluded under this Booklet or are not obtained in the way required by this Booklet. To learn more, read the exclusions in each covered benefit, the limits in the *Schedule of Benefits*, and the "Limitations/Exclusions (What Is Not Covered and Pre-Existing Conditions)" section of this Booklet.

Preventive Care Services

Preventive care includes the screenings and services listed below, when no sign or history of a health problem exists.

Preventive care does not include services when you have symptoms or have been diagnosed with a medical problem. Instead, those services will be considered for possible coverage under the Doctor Office Services or Diagnostic Services benefits below.

Preventive Care Services are covered as needed by the rules under federal and state laws, including but not limited to the Patient Protection and Affordable Care Act (PPACA), and are to become effective in accordance with those laws. Those laws, and your coverage, may change from time to time. Many Preventive Care Services are covered by this Booklet with no Deductible, Copayment or Coinsurance from the Member when provided by a participating Provider. These services fall under four broad types as shown below:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples are:

  - Breast cancer;

  - Cervical cancer;

  - Colorectal cancer;

  - High blood pressure;

  - Type 2 diabetes Mellitus;

  - Cholesterol; and

  - Child and adult obesity.

- Routine shots, including flu shots, for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

- Preventive care and screenings for children, adolescents, and adults are based on the comprehensive guidelines from the Health Resources and Services Administration. This includes child health supervision services.

- Other preventive care and screening for women are also covered based on the guidelines from by the Health Resources and Services Administration, including the following:

  - Women's contraceptives, sterilization procedures, and counseling. This includes Generic and Single Source Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants are also covered. You must get covered contraceptives from an In-Network pharmacy or participating Provider, if you don't they will not be covered. Multi-Source Drugs will be covered under the Retail Pharmacy/Home Delivery Pharmacy Prescription Drugs below.

  - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

  - Gestational diabetes screening.

- Additional women's Preventive Care Services include well-woman visits, HPV testing, counseling for sexually transmitted infections, counseling and screening for HIV, and counseling and screening for interpersonal and domestic violence.

To learn more, you can call Us using the number on your Health Benefit ID Card. Or you can view the federal government's web sites at:

http://www.healthcare.gov/what-are-my-preventive-care-benefits.html;

http://www.ahrq.gov/.html; and

http://www.cdc.gov/vaccines/acip/index.html

As required by state law, preventive care services also include:

- Routine screening mammogram;
- Routine cytologic screening (Pap test);
- Routine prostate specific antigen (PSA) blood test and digital rectal examination;
- Colorectal cancer examination, including colonoscopies and related laboratory tests;
- Routine PKU tests for newborns;
- Cholesterol screening for lipid disorders;
- Tobacco use screening of adults and tobacco cessation interventions by your Provider;
- Alcohol misuse screening and behavioral counseling interventions for adults by your Provider; and
- Cervical cancer vaccinations for females.

In addition to federal and state law rules, the following preventive care services are covered:

- Annual medical diabetes eye exams, or as often as your Provider decides; and
- Flu shot from a flu shot clinic. Coverage is provided for one flu shot per Benefit Period, or more often as We decide. Some places that may give flu shots are your local pharmacy, at your job, or a grocery store. There may be other flu shot clinic locations not listed. To learn more about how much We pay you back for a flu shot, and to get the claim form, visit Our website at www.anthem.com. You may also call Our member services. The amount We cover is subject to change. A flu shot paid for in full, or in part by someone else, is not eligible for coverage.

Infertility Diagnostic Services

We cover tests and services to find the cause of infertility. We do not cover the treatment of infertility.

Coverage for the diagnosis of infertility includes inpatient services, outpatient services, and Doctor office services. Coverage is also limited. See the *Schedule of Benefits* for the most We will pay in a lifetime. If you change coverage and the new coverage is within the same kind of benefit design, the same lifetime benefit applies. If you change your coverage to a benefit design that is different, a separate and new lifetime maximum benefit begins with the new coverage.

Maternity Services and Newborn Care

Coverage for maternity and newborn care covers inpatient services, outpatient services and Doctor office services for normal pregnancy. This includes one routine ultrasound and normal routine nursery care for a well newborn baby. We also cover complications of pregnancy, as needed by state law, and miscarriage. The newborn baby is covered for Medically Necessary care and treatment of injury and sickness, and medically diagnosed Congenital Defects and Birth Abnormalities.

After childbirth, We will cover the mother and the baby for at least 48 hours in a Hospital. If delivery is by cesarean section, coverage will be for at least 96 hours. If the baby is born between 8:00 p.m. and 8:00 a.m., coverage will continue until 8:00 a.m. on the morning after the 48 or 96 hours timeframe. But the mother and baby can leave sooner if the mother and Doctor or certified nurse midwife agree to do so.

At-home visits following child-birth are covered for you at your home by a Doctor, nurse or certified nurse midwife. This needs to be done within seventy-two (72) hours after you and your baby are released from the Hospital. Coverage for this visit includes, but is not limited to:

- Parent training;
- Physical assessments;
- Assessment of the home support system;
- Help 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 collecting samples for hereditary disease and metabolic newborn screening.

The mother can decide that this visit may happen at the Doctor's office.

We pay for Covered Services from a Provider for therapeutic or elective termination of pregnancy regardless if Medically Necessary, unless applicable law or regulation prohibits the employer from providing such coverage (in which case, Covered Services are provided only to the extent necessary to prevent the death of the mother or unborn baby).

Diabetes Management Services

We cover diabetes training and medical nutrition therapy if you have diabetes (whether or not it is insulin dependent), or if you have raised blood glucose levels caused by pregnancy. Other medical conditions may also qualify. But the services need to be ordered by a Doctor and given by a Health Care Professional who is certified, registered or with training in diabetes. Diabetes training sessions must be provided by a health care professional in an outpatient Facility or in a Doctor's office.

Screenings for gestational diabetes are covered under Preventive Care Services.

Doctor Office Services

We cover office visits when needed to check your health, or to discuss and find the cause of a health problem, or to get treatment and non-urgent and non-Emergency medical care. Services include getting second opinions on a condition, or discussing birth control or family planning. For allergies, We also cover office visits to get testing, shots and serum.

See this "Benefits/Coverage (What is Covered)" section for more information on prescription drugs administered in the office.

Some things like x-rays or lab tests or surgical services will not always be covered as an office visit, even if done in a Provider's office. Those services may be subject to additional Copayment or benefit restrictions. Also, there may be a limit on how many times you can visit a Doctor or Provider for certain treatments. Some examples are physical/speech therapy, or chiropractic therapy. To learn more, see the *Schedule of Benefits*.

When available in your area, your coverage will include online visit services. Covered Services include a medical session using the web by webcam, chat or voice.

Telemedicine Services

When you can't travel to a Provider's office, Telemedicine benefits might be available when provided by covered Providers. Telemedicine is the real-time transfer of health data and help. Services include the use of interactive audio, video, or other electronic media to discuss and treat your health problem. These services are covered if they would be Covered Services when given in a face-to-face meeting with the Provider. See your *Schedule of Benefits* for applicable Copayment.

There are limits. Telemedicine does not include the use of phones or fax machines. It also is not covered if you can go into the office of a In-Network Provider in the area where you live. Telemedicine benefits may also be limited to only certain areas in Colorado. Please check with Our member services to see if your area is eligible.

Non-Covered Services are:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to doctors outside the online care panel;
- Benefit Preauthorization; and

- Doctor talking to another Doctor.

Inpatient Services

Inpatient Hospital Services are for acute care in a Hospital. Benefits are for charges from a Hospital for room, board and general nursing services, ancillary (related) services, and services from a Doctor while you are in the Hospital. An inpatient admission may include physical, occupational and speech therapy services care as part of your acute admission. If an inpatient admission is only for the purpose of rehab see the next section for Inpatient Rehab Services since that care is limited.

Room, Board and General Nursing Services

- A room with two or more beds;
- A private room but only if it is Medically Necessary that you occupy a private room. For example a private room may be needed for isolation. If it is Medically Necessary for you to be in Hospital, but not in a private room, We will only allow benefits for the Hospital's average rate for a semi-private room; and
- A room in a special care unit approved by Us. The special care unit must be set up to give intensive care and support to critically ill patients.

Ancillary Services

- Operating, delivery and treatment rooms and supplies;
- Prescribed drugs given as part of the inpatient stay;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic services;
- Therapy services;
- General nursing care; and
- Charges for processing, transportation, handling and giving of blood. Charges for blood, blood plasma and blood products are covered unless the blood, blood plasma or blood products were given to you from a blood bank.

Other Services

- Medical care visits limited to one visit per day by any one professional Provider;
- Intensive medical care when your health problem requires it for a long time;
- If you are in the Hospital for Surgery, and your condition requires it, care by two or more Doctors during one Hospital stay may be covered;
- Being seen by another professional Provider when your professional Provider asks. But if the request is made just because of Hospital rules, coverage is not available;
- Surgery Services, including Reconstructive Surgery;
- Anesthesia, Anesthesia supplies and services; and
- Newborn examinations by a Doctor other than the Doctor who performed the obstetrical delivery.

Copayment Waiver

When you move from one Hospital to another Hospital on the same day, any Copayment stated in dollars per admission in the *Schedule of Benefits* is not applied for the second admission. Copayments stated as a percentage or per day are not waived.

Inpatient Rehab Services

If We determine that you no longer need acute Hospital care, or that the main reason for a Hospital stay is to restore or improve functions you have lost because of an injury or illness, We will consider the care to be Inpatient Rehab Therapy. We cover Inpatient Rehab Therapy up to the maximum number of days listed on the *Schedule of Benefits*.

Benefits for inpatient care are available while you are at a rehab facility for the **main reason** of getting rehab services. For example, if your care includes at least three hours of therapy, We may consider it Inpatient Rehab Therapy. Some therapies are speech therapy, respiratory therapy, occupational therapy and/or physical therapy. There may be differing levels of therapy, like Acute Rehab Therapy, Chronic Rehab Therapy or Sub-Acute Rehab Therapy. But to be eligible for benefits, rehab services must be aimed at goals that can likely be met in a reasonable period of time. Benefits are not available for Custodial Care. Benefits will end at the earlier of:

- When rehab is no longer Medically Necessary and you stop meeting those goals;
- When you have used up the day limit as listed on your *Schedule of Benefits*; or
- We decide that Maximum Medical Improvement is reached and no further major changes can be made.

Skilled Nursing Care Facility (SNF)

A Skilled Nursing Care Facility is a place that gives you skilled nursing care. Benefits are for charges from a Skilled Nursing Care Facility for room, board and general nursing services, ancillary (related) services, and services from a Doctor while you are in the Facility. For example it gives you therapies if you have an unstable or long term health problem. Skilled nursing care is given under health supervision for nonsurgical care of long term health problems or healing stages of short term health problems or injuries. Skilled Nursing Care Facility coverage does not include care for Members with significant medical needs. Also, benefits are not available for Custodial Care. The Facility Provider and its service must be covered and Preauthorized by Us.

Where covered, there may be separate limits on the number of days We cover for skilled nursing care. To learn more, see the *Schedule of Benefits.* If you use up the number of days allowed, or if We determine that you reached Maximum Medical Improvement and no further major changes can be made, further Skilled Nursing Care Facility services will be denied.

Outpatient Services

Outpatient Services are for both Facility and professional Provider charges when given to you in an Outpatient location. These can be places like a Hospital, Alternative Care Facility or other Facility Provider. Professional charges include services billed by a Doctor or other professional Provider in the outpatient location.

The services covered for Inpatient Services listed above are also covered for Outpatient Services. What is not covered is the room, board and general nursing services.

See the “Benefits/Coverage (What is Covered)” section for more information on Prescription Drugs administered as an outpatient procedure.

Diagnostic Services

Coverage for test are covered when they are done as part of preventive care services, Doctor office services, infertility services, outpatient services, home care services, hospice services, Emergency care and Urgent Care. Covered Services include:

- X-ray and other radiology;
- Lab and pathology;
- CT, MRI, MRA, PET tests;
- Ultrasounds;
- Allergy tests;
- Hearing tests, unrelated to an exam for prescribing or fitting of a hearing aid, except as required by law;
- Genetic tests if those tests are allowed by Our medical policy; and
- Ultrafast CT scans when Preauthorized and if those tests are allowed by Our medical policy.

Surgical Services

Surgery services are covered when part of a Doctor office service, or on an inpatient or outpatient basis for:

- Surgery or other types of operative services;

- Treating broken bones and dislocations;
- Sterilization services;
- Anesthesia and for an assistant surgeon, but only if allowed by Our medical policy. We do not pay for all surgical assistant procedures;
- Normal and related care, before and after Surgery; and
- Other types of services as approved by Us.
- Bariatric surgery and complications from bariatric surgery that satisfy Our medical policy and which are received from a designated facility are covered benefits. See the *Schedule of Benefits* for benefit limitations.

The surgical fee includes usual follow-up care that is Medically Necessary.

Note: If you are getting benefits for a covered mastectomy or for follow-up care for a covered mastectomy, and you decide to have breast reconstruction, you will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a balanced look; and
- Prostheses and for physical problems caused by any stage of the mastectomy, including lymphedemas.

This coverage will be provided in consultation with you and your attending physician and will be subject to the same Coinsurance, Copayment provisions otherwise applicable under the plan.

Transgender Surgery

This coverage provides benefits for many of the charges for transgender surgery (also known as sex reassignment surgery), where Medically Necessary as determined by our medical policies and guidelines. Covered Services must be approved by Us and must be authorized by Us prior to being performed. **Changes for services that are not authorized for the transgender surgery requested will not be considered Covered Services. Some conditions apply, and all services must be authorized by us as outlined in the "How to Access Your Services and Obtain Approval of Benefits" section.**

Emergency Care and Urgent Care

It is good to know the difference between an Emergency and when your situation is Urgent.

Emergency Care

An Emergency is where a prudent person, having average knowledge of health services and medicine and acting reasonably, believes that immediate medical care is needed to prevent death or serious harm to life or limb. In cases of Emergency, services are covered from either an In-Network Provider or Out-of-Network Provider. For Emergency care from an Out-of-Network Provider, you will not need to pay more than what you would have if you had seen an In-Network Provider.

We cover Emergency services needed to screen and Stabilize you without Preauthorization. But once you are stabilized any further or follow-up care is not considered Emergency care.

For inpatient admissions after Emergency care, you should get in touch with Us within seventy-two hours of being in admitted or as soon as reasonably possible to obtain authorization for the continued stay.

Urgent Care

Sometimes the type of you care you need is Urgent and it not an Emergency. Urgent Care can be received from an In-Network Provider or an Out-of-Network Provider. For Urgent Care from an Out-of-Network Provider, you will not need to pay more than what you would have if you had seen an In-Network Provider. If you have an Accidental Injury or a medical problem, We will decide whether your injury or medical problem is Urgent Care or Emergency Care for coverage purposes, based on your diagnosis and symptoms.

Urgent Care is when you need immediate medical attention but your condition is not life-threatening (non-Emergency). Treatment of an Urgent Care health problem is not an Emergency and does not need the use of an emergency room at a Hospital. If you call your Doctor before receiving care for an urgent health problem and you are told to go to an emergency room, your care will be paid at the level specified in the *Schedule of Benefits* for Urgent Care.

Obtaining Emergency or Urgent Care

If you need Emergency Care or Urgent Care, even while you are outside Our Service Area, you are covered. Please follow the step-by-step instructions below to help make sure you receive coverage:

- Know the difference between an Emergency and an Urgent Care situation;
- If you are having an Emergency, call 9-1-1 or go to the nearest Hospital. If you are having an Urgent Care health problem, go to an Urgent Care Center or your Doctor's office. If there is not one nearby, then go to the Hospital;
- Call your Doctor or Us within seventy-two hours or as soon as you reasonably can;
- 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 ID Card to the Hospital staff or Doctor. If the Hospital or Urgent Care Center 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. For Covered Services, you only have to pay any cost shares as stated in your *Schedule of Benefits*; and
- You will receive an Explanation of Benefits form.

Ambulance and Transportation Services

Medically Necessary Ambulance and Emergency Ambulance services are Covered Services when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.
- For ground Ambulance, you are taken:
  - From your home, the scene of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when We require you to move from an Out-of-Network Hospital to an In-Network Hospital;
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility;
  - From a Hospital or Skilled Nursing Care Facility to your home.
- For air or water Ambulance, you are taken:
  - From the sce**n**e of an accident or medical Emergency to a Hospital;
  - Between Hospitals, including when We require you to move from an Out-of-Network Hospital to an In-Network Hospital;
  - Between a Hospital and an approved Facility.

Emergency Ambulance services do not require Preauthorization and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. For Emergency Ambulance services from by an Out-of-Network Provider you do not need to pay any more than would have been paid for services from an In-Network Provider.

Non-Emergency Ambulance services are subject to Medical Necessity reviews by Us. When using an air Ambulance for non-Emergency transportation, We reserve the right to select the air Ambulance Provider. For non-Emergency services if you do not use the air Ambulance Provider We select services will not be covered.

You must be taken to the nearest Facility that can give care for your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals from an Ambulance service, even if you are not taken to a Facility.

Important Notes on Air Ambulance Benefits

Benefits are only available for air Ambulance when it is not appropriate to use a ground or water Ambulance. For example, if using a ground Ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground Ambulance can provide, We will cover the air Ambulance. Air Ambulance will also be covered if you are in an area that a ground or water Ambulance cannot reach.

Air Ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Doctor's office or your home.

Hospital to Hospital Transport
If you are moving from one Hospital to another, air Ambulance will only be covered if using a ground Ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air Ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Doctor.**

Therapy Services

The following therapy services are covered when done in the Doctor's office, as part of an inpatient admission, when done outpatient or as part of Home Care service.

Physical, Speech, and Occupational Therapy

For children under age 6, We cover at least 20 visits, each, of physical, speech and occupational therapy. Benefits include the treatment of Congenital Defects and Birth Abnormalities, even if it a long term condition. It also doesn't matter if the reason for the therapy is to maintain (not improve) the child's skills. For children between 3 and 6 with Autism Spectrum Disorders, We cover more than 20 visits of each therapy if part of a Member's Autism Treatment Plan and determined Medically Necessary by Us.

From the Members birth until the Member's third (3rd) birthday, these services shall be provided only where and only to the extent required by applicable law.

If you are 6 or older, We cover the number of visits listed on the *Schedule of Benefits.* Coverage is given only if the physical, speech or occupational therapy will result in a practical improvement in the level of functioning in a short period of time and is Medically Necessary.

- **Physical therapy** includes care by physical means like, hydrotherapy, heat or like modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Physical therapy is given to help pain, return function and to prevent disability after a health problem, or as a result of a Congenital Defect or Birth Abnormality;
- **Speech therapy** is covered where We decide it's Medically Necessary to correct a speech problem caused by an injury, health problem or Congenital Defect or Birth Abnormality. For a cleft palate or cleft lip, Medically Necessary speech therapy is not limited, but those visits lower the number of speech therapy visits available to treat other problems; and
- **Occupational therapy** is covered to treat physical disabilities or a Congenital Defect or Birth Abnormality. The therapy needs to be designed to help your ability to do the usual tasks of your daily living or your job.

Other Therapy Services

- **Chiropractic therapy** services are covered when:

  - within the scope of chiropractic care that supports or is needed to help you reach the physical state enjoyed before the health problem; and

  - the services are usually given to diagnose or treat a neuromusculoskeletal health problem linked to an injury or illness.

  Coverage is provided for examinations, office visits with manual adjustment of the spine, x-ray of the spine and conjunctive physiotherapy. Coverage is provided regardless of who provides the Covered Services as long as the

Provider is licensed to provide such care. Benefits are up to the number of visits as listed on the *Schedule of Benefits*;

- **Acupuncture /Nerve Pathway therapy** is limited to the treatment of neuromusculoskeletal pain, through the use of needles inserted along specific nerve pathways to ease pain resulting from an injury or illness. Benefits are up to the number of visits as listed on the *Schedule of Benefits*;
- **Cardiac Rehab** to repair an individual's functional status after a cardiac event. Benefits are allowed at a facility for exercise and education under the direct supervision of a professional Provider in an intensive outpatient rehab program. From 6 to 36 visits per event are allowed based on Our medical policy;
- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents. Chemotherapy services can be given at the Providers office. See this "Benefits/Coverage (What is Covered)" section under Prescription Drugs Administered by a Medical Provider for more information;
- **Dialysis** treatments for a short term or chronic kidney illness which may include the 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 health problem by the using medicines, water vapors, gases, or anesthetics by inhalation; and
- **Osteopathic Manipulative Therapy** services to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Benefits are up to the number of visits as listed on the *Schedule of Benefits*.

Early Intervention Services

From the Member's birth until the Member's third (3rd) birthday We cover Early Intervention Services. Services (as defined in this Booklet and by Colorado law in accordance with Part C), that are authorized through an eligible child's individualized family service plan (IFSP) and delivered by a Qualified Early Intervention Service Provider to an eligible child, to the extent required by applicable law. The services stated in an IFSP will be considered Medically Necessary. Coverage for early intervention services does not include: nonemergency medical transportation; respite care; service coordination, as defined in federal law; or assistive technology (unless covered under the applicable insurance policy as durable medical equipment). Coverage is limited to up to 45 visits per Benefit Period.

This visit limit does not apply to rehabilitation or therapeutic services that are necessary as the result of an acute medical condition or post-surgical rehabilitation or services provided to a child who is not participating in Part C. The coverage for Early Intervention Services is in addition to any other coverage provided under this Booklet for congenital defects or birth abnormalities.

Autism Spectrum Disorders

Covered Services are provided for the assessment, diagnosis, and treatment of Autism Spectrum Disorders (ASD) for a covered child. See the *Schedule of Benefits* for the maximum benefits associated with Applied Behavior Analysis for specific age categories. The following treatments will not be considered Experimental or Investigational and will be considered appropriate, effective, or efficient for the treatment of Autism Spectrum Disorders where We determine such services are Medically Necessary:

- Evaluation and assessment services;
- Behavior training and behavior management and Applied Behavior Analysis, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, for Autism Spectrum Disorders provided by Autism Services Providers;
- Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies.
- Prescription Drugs, if covered under this Booklet;
- Psychiatric care;
- Psychological care, including family counseling; and
- Therapeutic care.

Treatment for Autism Spectrum Disorders must be prescribed or ordered by a Doctor or psychologist, and services must be provided by a Provider covered under this plan and approved to provide those services. However, behavior training, behavior management, or Applied Behavior Analysis services (whether provided directly or as part of Therapeutic Care), must be provided by an Autism Services Provider. Coverage of Autism Spectrum Disorders in this "Benefits/Coverage (What Is Covered)" section is in addition to coverage provided for early intervention and Congenital Defects and Birth Abnormality. Autism services and the Autism Treatment Plan are subject to Utilization Review.

Home Care/Home IV Therapy Services

Home health services are performed by a Home Health Agency or other Provider in your home. They must be given on a part-time visiting basis for your course of treatment. Refer to your *Schedule of Benefits* for benefit limitations. Covered Services include the following:

- Professional nursing services you get from a registered nurse (R.N.) or a licensed practical nurse (L.P.N);
- Health care/social services;
- Diagnostic services;
- Nutritional guidance;
- Certified nurse aide services under the supervision of an R.N. or a therapist skilled in professional nursing services;
- Therapy Services like physical, occupational, respiratory, inhalation, speech and hearing therapy. Therapy services are not subject to the therapy limits listed under the *Schedule of Benefits* when provided by a Home Health Agency;
- Social work practice services from a social worker;
- Medical and surgical supplies;
- Durable medical equipment; and
- Prescription Drugs but only if provided and billed by a Home Health Care Agency.

Home IV Therapy

Home IV therapy is covered and includes a mixture of nursing care, durable medical equipment and IV pharmaceutical services. These are delivered and/or given 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 after a Hospital discharge when it is Medically Necessary. More days may be given up to a maximum of 42 days per Benefit Period when preauthorized by Us. Aside from the limits above, home IV therapy services are not subject to the home health care limits listed on the *Schedule of Benefits*.

See this "Benefits/Coverage (What is Covered)" section under the "Prescription Drugs Administered by a Medical Provider" for more information.

Nutritional Counseling

Nutritional counseling is a way of looking at your food habits and choices with a food expert who offers diet changes and food ideas right for you. The goal of nutrition counseling is to make the right food choices, and improve the nutritional value and dietary supplements in your diet. Benefits are given for a registered dietitian who is a health worker who knows about diet and foods and who is able to translate that information into the right food choices. Registered dietitians must limit their practice to those methods which conform with state and federal laws. Benefits include:

- Nutritional techniques of evaluation which give measurements and changes;
- Nutritional counseling;
- Nutritional therapy; and
- Help on nutritional supplements.

Coverage is not given for foods, hypnosis, personal training, supplements or vitamins.

Nutritional counseling for the treatment of eating disorders, such as anorexia nervosa and bulimia nervosa is covered under the "Mental Health and Substance Abuse Services" section.

Nutritional counseling provided as part of a preventive visit will be covered under "Preventive Care Services".

Nutritional counseling provided as part of diabetes management will be covered under “Diabetes Management Services”. Benefit will be based on place of service.

Medical Foods

Benefits are given for medical foods for home use for metabolic disorders which may be taken by mouth 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, if you are 21 or younger (35 or younger for women of child-bearing age);
- Maternal phenylketonuria;
- Maple syrup urine disease;
- Tyrosinemia;
- Homocystinuria;
- Histidinemia;
- Urea cycle disorders;
- Hyperlysinemia;
- Glutaric acidemias;
- Methylmalonic academia; and
- Propionic acidemia.

These benefits do not include enteral nutrition therapy or medical foods for Members with cystic fibrosis or lactose- or soy-intolerance. Also all covered medical foods must be obtained through an In-Network Pharmacy and are subject to the pharmacy payment requirements.

Hospice Care

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Hospice care includes routine home care, constant home care, inpatient Hospice and inpatient respite. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care;
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care;
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse;
- Doctor services and diagnostic testing;
- Social services and counseling services from a licensed social worker;
- Nutritional support such as intravenous feeding and feeding tubes and nutritional counseling;
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist;
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies;
- Prosthetics and orthopedic appliances;
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member’s death. Bereavement services are available to the patient/family consisting of those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties; and

- Transportation.

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than six months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to Us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Booklet. Any care you get that has to do with an unrelated illness or medical condition will be subject to the provisions of this plan that deals with that illness.

Human Organ and Tissue Transplant Services

Covered Services are paid as inpatient services, outpatient services, or Doctor home visits and offices services depending on where the services is given and subject to your cost shares.

Covered Transplant Procedure

We cover Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and transfusions as determined by Us when Preauthorized. This includes necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Covered transplant procedures include:

- Heart;
- Lung (single or double);
- Heart-Lung;
- Kidney-Pancreas;
- Pancreas;
- Liver;
- Bone Marrow/Peripheral Stem Cell/Cord Blood;
- Small bowel; and
- Multivisceral.

This list may change based on Our medical policy. If you are eligible for Medicare (or think you will be in the future), it is up to you to contact Medicare to see if you transplant will be covered by Medicare.

Immunosuppressant drugs prescribed for outpatient used with a covered human organ and tissue transplant that are given 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.

As used under this section, the term donor means a person who gives organs for transplantation. If a human organ or tissue transplant is given from a donor to the person receiving the transplant, the following apply:

- When both the person getting the transplant and the person donating the organ are Our covered Members, each is entitled to the Covered Services given under the human organ and tissue transplant benefits;
- When only the person getting the transplant is a covered Member, the person donating and the person getting the transplant are entitled to the Covered Services given under the Human Organ and Tissue Transplant benefits;
- The donor benefits are limited to those not given or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, grants, foundations, government programs, etc.; and
- If the person giving the organ is Our covered Member, and the person getting the transplant is not covered by Us, benefits will not be given for the donor or recipient expenses.

Coverage includes Covered Services for the live donor and/or donated organ or tissue. This can be for such things as Hospital, surgical, medical, storage and transportation costs (including problems from the donor procedure for up to 6 weeks from the date of getting the organ).

Benefits are given for donor searches that are not part of your family for bone marrow/stem cell transplants for a covered transplant procedure. Benefits for donor searches that are not part of your family for bone marrow/stem cell donor searches are limited to the maximum as listed on the *Schedule of Benefits*.

In-Network Transplant Provider

A Provider that We have chosen as a "Center of Excellence" and/or a Provider selected to take part as an In-Network transplant Provider by a designee. The Provider has entered into a transplant Provider agreement to give covered transplant procedures and certain administrative duties for the transplant network. A Provider may be an In-Network transplant Provider for:

- Certain covered transplant procedures; or
- All covered transplant procedures.

Transplant Benefit Period

At an In-Network transplant Provider facility, the Transplant Benefit Period starts one day prior to a covered transplant procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network transplant Provider agreement. Call the case manager for specific In-Network transplant Provider details for services received at or coordinated by an In-Network transplant Provider facility. At the end of the case rate / global time period, benefit are provided under the Doctor Office Services, Inpatient Services, and Outpatient Services section of the Booklet, depending on where the service is performed and are not subject to the terms of this Human Organ and Tissue Transplant section.

Prior Approval and Preauthorization

To maximize your benefits, you should call Our transplant department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you to maximize your benefits by giving coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network transplant rules, or exclusions apply. Call the member services phone number on the back of your Health Benefit ID Card and ask for the transplant coordinator. Even if We give a prior approval for the covered transplant procedure, you or your Provider must call Our transplant department for Preauthorization prior to the transplant whether this is performed in an inpatient or outpatient setting.

Preauthorization is required before We will cover benefits for a transplant. Your Doctor must certify, and We must agree, that the transplant is Medically Necessary. Your Doctor should submit a written request for Preauthorization to Us as soon as possible to start this process. Not getting Preauthorization will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is not an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the covered transplant procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to Us when claims are filed. Call Us for detailed information. Benefits for travel and lodging are limited to the maximum as listed on the *Schedule of Benefits*.

For lodging and ground transportation benefits, We will cover costs up to the current limits set forth in the Internal Revenue Code.

Limits

Certain human organ and tissue transplant services may be limited. See the *Schedule of Benefits*.

Also, the human organ and tissue transplant (bone marrow/stem cell) services, benefits or rules described above do not apply to the following:

- Kidney;

- Cornea; and
- Any Covered Services for a covered transplant procedure received before or after the Transplant Benefit Period. Note: the harvest and storage of bone marrow/stem cells is included in the covered transplant procedure benefit above no matter the date of service.

The above Covered Services are paid as Doctor Office Services, Inpatient Services, and Outpatient Services under this Booklet depending on where the service is performed. Benefits are not covered for transportation, lodging and meals for those services listed above.

Medical Supplies, Durable Medical Equipment, and Appliances

The supplies, equipment and appliances described below are covered under this benefit. But if We decide that the medical supply, equipment and/or appliances includes comfort, luxury or convenience items, We only allow up to the Maximum Allowed Amount for a standard covered item.

Medical and Surgical Supplies

We cover syringes, needles, oxygen, surgical dressings, splints and other like items that serve only a health purpose, including diabetic supplies.

Durable Medical Equipment

We cover the rental (or, at Our choice, the purchase) of durable medical equipment prescribed by a Doctor or other Provider. The rental cost must not be more than the price to buy the equipment. This equipment must serve only a health care purpose and be able to withstand repeated use. If We cover a piece of medical equipment, We also cover the repair of that equipment.

Prosthetic Devices

We cover purchase, fitting, needed changes, 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 a permanently ineffective or non-functioning body part.

We also cover prosthetic arms and legs to the benefit amounts provided by federal laws for Medicare or where needed to meet state insurance law.

Benefits for prosthetic devices include:

- Either one set of standard prescription glasses or one set of contact lenses (whichever is right for the health problem) when needed 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 bras each Benefit Period after a mastectomy; and
- The first wig after cancer treatment.

Orthopedic Appliances

We cover the purchase, fitting, needed changes, repairs, and replacements of Orthopedic Appliances and supplies. These are rigid or semi-rigid supportive devices and items that limit or stop motion of a weak or diseased body part.

Foot Orthotics and orthopedic shoes are not covered (unless you have diabetes).

Hearing Aid Services

For children under 18, subject to the terms of the Booklet, We cover the following hearing aids and the services that go with them when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist:

- Audiological testing to measure the level of hearing loss and to choose the proper make and model of a hearing aid. These evaluations will be provided under other benefits of this “Benefits/Coverage (What Is Covered)” section for diagnostic services;
- Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment. We cover auditory training when it is offered using approved professional standards. Initial and

replacement hearing aids will be supplied every 5 years, a new hearing aid may be a covered service when alterations to your existing hearing aid cannot adequately meet your needs or be repaired; and

- Visits for fitting, counseling, adjustments and repairs after receiving the covered hearing aid.

Dental Related Services

Accident-Related Dental Services

This Booklet is not meant to provide or replace dental insurance. Benefits are provided for dental work and oral Surgery if they are for the initial repair of an Accidental Injury to the jaw, sound natural teeth, or related body tissue, mouth or face and only if received within seventy-two (72) hours of the accident. Such dental services do not include dental restoration. All dental services received after seventy-two (72) hours following the accident are not covered. Injury as a result of chewing or biting is not considered an Accidental Injury, unless the chewing or biting results from a medical or mental condition.

Dental Anesthesia

Benefits are given for general Anesthesia from a Hospital, outpatient surgical facility or other facility, and for the Hospital or facility charges needed for dental care for a covered Dependent child who:

- Has a physical, mental or medically compromising condition;
- Has dental needs for which local Anesthesia is not effective because of acute infection, anatomic variation or allergy;
- Is extremely uncooperative, unmanageable, uncommunicative or anxious and whose dental needs are deemed sufficiently important that dental care cannot be deferred; or
- Has sustained extensive orofacial and dental trauma.

Cleft Palate and Cleft Lip Conditions

Benefits are given for inpatient care and outpatient care, including:

- Orofacial Surgery;
- Surgical care and follow-up care by plastic surgeons and oral surgeons;
- Orthodontics and prosthodontic treatment;
- Prosthetic treatment such as obturators, speech appliances, and prosthodontic; 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 main policy and must fully cover orthodontics and dental care for cleft palate and/or cleft lip conditions.

Other

The only other dental costs that are Covered Services are facility charges for inpatient and/or outpatient services. Benefits are payable in such settings only if the Member's health problem or the dental treatment calls for it to keep you safe.

Mental Health and Substance Abuse Services

We cover inpatient services, outpatient services and Doctor office services for the care of Mental Health and Substance Abuse. These services include diagnosis, crisis intervention and short-term care of mental health conditions and for rehab of substance dependency.

Coverage for mental health care is for a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition. It does not include Autism Spectrum Disorder, which under state law is considered a medical condition. Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) care is covered under this section if the services are given by a mental health Provider.

Substance Dependency benefits are for acute medical detox and for rehab. This care is covered when given by a covered Provider Center. Substance Dependency is what happens when you use alcohol or other drugs in a way that harms your health or destroys your ability to control your actions. The main reason for medical detox is to get rid of the toxins in your body, and check your heart rate, blood pressure and other vital signs. Medical detox helps with your

withdrawal signs and it gives you medicines as needed. Rehab includes the services and treatment listed below, to help you stop abusing alcohol or drugs.

Inpatient Services. Inpatient care to treat Mental Health and Substance Abuse includes:

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

Outpatient Services. The same services listed above for inpatient are covered on an outpatient basis. What are not covered are room, board and general nursing services. Outpatient services include intensive outpatient treatment.

Partial Hospitalization Services. The same services covered for outpatient services for Mental Health and Substance Abuse are covered when you are in the Hospital for only part of the day. Partial hospitalization treatment is covered only when you receive Medically Necessary care through a day treatment program as decided by the facility.

We also cover medicine management for Mental Health and Substance Abuse when given by your medical Doctor, psychiatrist or prescriptive nurse. If the medicine management is given by your medical Doctor, benefits are paid under your medical benefit. If medicine management is given by a psychiatrist or prescriptive nurse, benefits are paid under your mental health benefit. For coverage of Prescription Drugs, see this "Benefits Coverage (What Is Covered)" section.

Preauthorizations. Your Doctor should call Our behavioral health administrator to find out Medical Necessity needs, correct treatment level and proper setting. Non Emergency inpatient services need Preauthorization. See the "How to Access Your Services and Obtain Approval of Benefits" section for information

Prescription Drugs Administered by a Medical Provider

We cover Prescription Drugs when they are administered to you as part of a Doctor's visit, home care visit, or at an outpatient facility. This includes drugs for infusion therapy, chemotherapy, specialty drugs, blood products, and office-based injectable that must be administered by a Provider. This section applies when your Provider orders the drug and administers it to you. Benefits for drugs that you can inject or get at a Pharmacy (i.e., self-administered injectable drugs) are not covered under this section. Benefits for those drugs are described in the Retail Pharmacy/Home Delivery Pharmacy Prescription Drugs or Specialty Pharmacy Drugs sections.

Note: When Prescription Drugs are covered under this benefit, they will not also be provided under the Retail Pharmacy/Home Delivery Pharmacy Prescription Drugs or Specialty Pharmacy Drugs benefits. Also, if Prescription Drugs are covered under the Retail Pharmacy/Home Delivery Pharmacy Prescription Drugs or Specialty Pharmacy Drugs benefits, they will not be covered under this benefit.

Important Details About Prescription Drug Coverage

Your plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked for more details before We can decide if the drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/ or Pharmacy and Therapeutics (P&T) Process.

Preauthorization

Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Preauthorization should be given. We will give the results of Our decision to both you and your Provider.

If Preauthorization is denied you have the right to file a Grievance as outlined in the "Appeals and Complaints" section of this Booklet.

For a list of drugs that need Preauthorization, please call the phone number on your Health Benefit ID Card. The list will be reviewed and updated from time to time. Including a drug or related item on the list does not promise coverage under this Booklet. Your Provider may check with Us to verify drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic drugs covered under this Booklet.

Step Therapy

Step therapy is a process in which you may need to use one type of drug before We will cover another. We check certain Prescription Drugs to make sure proper prescribing guidelines are followed. These guidelines help you get high quality yet cost effective Prescription Drugs. If a Doctor decides that a certain drug is needed, the Preauthorization process will apply.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctor about alternatives to certain prescribed drugs. We may contact you and your prescribing Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, please call the phone number on your Health Benefit ID card.

Retail Pharmacy/Home Delivery Pharmacy Prescription Drugs

Our outpatient pharmacy benefits are for medications filled at a Retail Pharmacy or Home Delivery Pharmacy. You must get covered Prescription Drugs and supplies from an In-Network pharmacy, if you don't they will not be covered. All Prescription Drugs must be on Our Prescription Drug List to be covered.

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 provided by a Specialty Pharmacy. See this "Benefits/Coverage (What Is Covered)" section for other Covered Services covered by the Booklet. Specialty Pharmacy Drugs listed on Our Specialty Drug List must be filled at a Specialty Pharmacy. See this "Benefits/Coverage (What Is Covered)" section for more information.

For Prescription Drugs, including Specialty Pharmacy Drugs, which are administered to you in a medical setting (e.g., Doctor's office, home care visit, or outpatient Facility), see this "Benefits/Coverage (What Is Covered)" section for more information.

The Outpatient pharmacy benefits available under this Booklet are managed by the Pharmacy Benefits Manager (PBM). The PBM is the company that We have contracted with to administer the Prescription Drug benefits. The PBM offers a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and a Specialty Pharmacy. You may review the current Prescription Drug List on Our website at www.anthem.com, under prescription benefits. You may also request a copy of the Prescription Drug List by calling Our member services. The Prescription Drug List is subject to change. Just because a drug or related item is on the list is not a promise of coverage.

For certain Prescription Drugs, the prescribing Doctor may be asked to provide additional information so that We can determine if Medically Necessary. We may establish quantity limits for specific Prescription Drugs. The PBM 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 if the drug you receive is a first, second, third or fourth tier drug. See the *Schedule of Benefits* to determine the associated Copayment for each tier. The amount of benefits paid is based upon whether you obtain covered drugs and supplies from an In-Network Retail Pharmacy or Home Delivery Pharmacy. A Prescription Drug must be a Legend Drug to be eligible for benefits.

The amount of benefits paid is based upon whether you obtain covered drugs and supplies from a Retail Pharmacy or Home Delivery Pharmacy. A Prescription Drug must be a Legend Drug to be eligible for benefits.

Certain Legend Drugs may also be used for treatment of cancer even though it has not been approved by the Food and Drug Administration (FDA) for treatment of a specific type of cancer, if the following conditions are met:

- the off-label use of the FDA approved drug is supported for the treatment of cancer by the authoritative reference compendia identified by the Department of Health and Human Services; and
- the condition being treated is covered under this Booklet.

We have established a Pharmacy and Therapeutics (P&T) Process, in which health care professionals, including nurses, pharmacists and doctors determine the clinical appropriateness of drugs and promote access to quality medications. This process also reviews drugs to determine the most cost effective use of benefits and advise on programs to help improve care. Our programs may include, but are not limited to, drug utilization programs, Preauthorization criteria, therapeutic conversion programs, cross-branded initiatives and drug profiling initiatives.

The determination of tiers is made by Us using information from the P&T Process. In addition We use 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 choices and where appropriate, certain clinical economic factors.

We keep the right to decide coverage for dosage formulations. This means what administration methods are covered. For example We may cover the drug by mouth, injections, topical, or inhaled and may cover one form of administration and not cover 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 has low cost or preferred medications. This tier may include Generic Drugs, Single Source Drugs and Multi-Source Drugs.

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

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

Tier-4 - means drugs with the highest Copayment. This tier has medications which are generally highest in cost. This tier may include Generic Drugs, Single Source Drugs, and Multi-Source Drugs.

The Provider or pharmacist can check with Us to verify drug tier placement, any quantity limits, Step Therapy, Preauthorization requirements, or appropriate Brand Name Drugs or Generic Drugs covered under the Booklet.

When your Provider writes a prescription for a drug that requires Step Therapy, the PBM will let the pharmacy know that you must first try a different, comparable drug that is covered. The pharmacy will contact your Provider to ask if the prescription can be changed to the covered drug. If the recommended drug is not right for you, your Provider can ask for a different one through the Preauthorization process.

Certain Prescription Drugs, or the prescribed quantity of a particular drug, may need Preauthorization. At the time you fill a prescription, the pharmacy is told about any Preauthorization requirements through the pharmacy's computer system. For a list of current drugs requiring Preauthorization, contact Our member services, or review the list on Our website at www.anthem.com.

From time to time We may start various voluntary programs to encourage you to use more cost-effective or clinically-effective drugs. This includes but is not limited to using Generic Drugs, home delivery 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 stop a program at any time. If you are participating in a program that We have stopped We will give you at least a 30 day advance written notice of the discontinuance.

Outpatient pharmacy benefits received from an In-Network pharmacy or Home Delivery Pharmacy are limited to:

- Prescription Drugs, including self-administered injectable drugs. These are Prescription Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit in this section;
- Injectable insulin and syringes used for administration of insulin;
- Oral contraceptive drugs and contraceptive devices. Certain contraceptives are covered under Preventive Care Services;
- Certain supplies, equipment and appliances (such as those for diabetes). You may contact Us to determine supplies covered through a pharmacy;
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the Preventive Care Services section; and
- FDA approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 and older. These products will be covered under the Preventive Care Services section.

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 Prescription Drug Maximum Allowed Amount. The Copayment will not be reduced by any discounts, rebates or other funds received by Us or the PBM from drug manufacturers, or similar vendors and/or funds received by Us and or

the PBM. We will not pay for a covered drug or supply unless the Prescription Drug Maximum Allowed Amount is more than the Copayment that you have to pay. See *the Schedule of Benefits* to determine the associated Copayment.

You are limited a 30-day supply of a Prescription Drug if obtained at an In-Network Retail Pharmacy or up to a 90-day supply if received from a In-Network Home Delivery Pharmacy. 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 Doctor to take "1/2 tablet daily" of those drugs on the approved list. The P&T Process will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and your decision to take part should follow consultation with and agreement by your Doctor. This program is only available through a Retail Pharmacy or Home Delivery Pharmacy. To get a list of the products available on this program contact member services.

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

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

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, a Brand Name Drug. However, if a Generic Drug is available, you will need to pay the cost difference between the Generic Drug and Brand Name Drug. The difference in cost is in addition to your tier Copayment for the drug. The cost difference between the Generic Drug and Brand Name Drug does not go towards your Out-of-Pocket Annual Maximum. By law, Generic Drugs and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics as a rule saves money, yet provides the same quality. We keep the right to remove certain higher cost Generic Drugs from this policy.

Home Delivery Pharmacy

You may also purchase your Maintenance Drugs by utilizing the In-Network Home Delivery Pharmacy and have your prescription sent directly to your home. To receive your Maintenance Drugs by mail, follow these 3 steps:

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

Please allow 7-14 days for processing and shipping of your order. Orders can be tracked on Our website via MyHealth@Anthem at www.anthem.com.

Helpful Tip: We suggest that you order your refill two weeks before you need it to avoid running out of your drugs. Any questions concerning the Home Delivery Pharmacy program, contact member services.

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 home delivery prescription. You may use Our website at www.anthem.com under MyHealth@Anthem or contact Our member services to obtain the mailing address for the Home Delivery Pharmacy.

Specialty Pharmacy Drugs

Certain Specialty Pharmacy Drugs obtained from a Retail Pharmacy must be ordered through a Specialty Pharmacy by you or your Provider. Those drugs are the ones listed on Our Specialty Drug List. You must get covered Specialty Pharmacy Drugs from an In-Network Pharmacy, if you don't they will not be covered.

Specialty Pharmacy Drugs are high-cost, injectable, infused, oral or inhaled medications that as a rule need close supervision and monitoring by a medical professional. These drugs often require special handling such as temperature controlled packaging and overnight delivery and often cannot be filled at a Retail Pharmacy or through a Home Delivery

Pharmacy. Benefits are only provided when you get your specialty drugs from an In-Network Specialty Pharmacy for those Specialty Pharmacy Drugs included on the Specialty Drug List.

The Outpatient Specialty Pharmacy benefits available under this Booklet are managed by the Pharmacy Benefits Manager (PBM). The PBM is the company that We have contracted with to administer the Prescription Drug benefits including Specialty Pharmacy Drugs. The PBM offers a Specialty Pharmacy which sends medications to you by overnight mail or mail service for up to a 30-day supply (you cannot pick up your medication from the Specialty Pharmacy). A Specialty Pharmacy is not a Retail Pharmacy or a Home Delivery Pharmacy.

Specialty Pharmacy services are for Specialty Pharmacy Drugs that you do not get from a Retail Pharmacy, in the Hospital as an inpatient, if a Medical Supply, Durable Medical Equipment or appliance. See this "Benefits/Coverage (What Is Covered)" section for other Covered Services covered by the Booklet. This section covers Specialty Pharmacy Drugs that must be filled by a Specialty Pharmacy which will be used in place of getting the service from your Doctor's office, Retail Pharmacy or other Specialty Pharmacy unless you qualify for an exception.

We have established a Pharmacy and Therapeutics (P&T) Process, in which health care professionals, including nurses, pharmacists and doctors determine the clinical appropriateness of drugs and promote access to quality medications. This process also reviews drugs to determine the most cost effective use of benefits and advise on programs to help improve care. Our programs may include, but are not limited to, drug utilization programs, Preauthorization criteria, therapeutic conversion programs, cross-branded initiatives and drug profiling initiatives.

The determination of tiers is made by Us using information from the P&T Process. In addition We use 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 choices and where appropriate, certain clinical economic factors.

We keep the right to decide coverage for dosage formulations. This means what administration methods are covered. For example We may cover the drug by mouth, injections, topical, or inhaled and may cover one form of administration and not cover or place other forms of administration on another tier.

With respect to orally administered cancer chemotherapy, benefits will not be less favorable than the benefits for cancer chemotherapy that is administered intravenously or by injection. In order to be prescribed, oral chemotherapy must be found to be Medically Necessary by the treating Doctor for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in the terms of type, frequency, extent, site, and duration, and not primarily for the convenience of the patient, Doctor, or other Provider. We may apply Our Drug List or clinical management requirements to any oral chemotherapy.

You may review the current Specialty Drug List on Our website at www.anthem.com. You may also request a copy of the list by calling Our member services. Our Specialty Drug List is subject to change. Just because a drug or related item is on the list is not a promise of coverage.

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

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

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

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

Tier-4 - means drugs with the highest Copayment. This tier has medications which are generally highest in cost. This tier may include Generic Drugs, Single Source Drugs, and Multi-Source Drugs.

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, a Brand Name Drug. However, if a Generic Drug is available, you will need to pay the cost difference between the Generic Drug and Brand Name Drug. The difference in cost is in addition to your tier Copayment for the drug. The cost difference between the Generic Drug and Brand Name Drug does not go towards your Out-of-Pocket Annual Maximum. By law, Generic Drugs and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics as a rule saves money, yet provides the same quality. We keep the right to remove certain higher cost Generic Drugs from this policy.

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 Prescription Drug Maximum Allowed Amount. The Copayment will not be reduced by any discounts, rebates or

other funds received by Us or the PBM from drug manufacturers, or similar vendors and/or funds received by Us and or the PBM. We will not pay for a covered drug or supply unless the Prescription Drug Maximum Allowed Amount is more than the Copayment that you have to pay. See *the Schedule of Benefits* to determine the associated Copayment.

We use many different administrative processes and tools, such as Preauthorization for health care services. These help Us decide the most right use and cost-effective alternatives available to Our Members. Certain Specialty Pharmacy Drugs, such as oral chemotherapy drugs, may require Preauthorization. At the time you fill a prescription, you will be informed if Preauthorization is needed. For a list of current drugs requiring Preauthorization, contact Our member services, or review the list on Our website at www.anthem.com. You can also check with Us to check on the drug tier placement or Preauthorization requirements.

From time to time We may start various voluntary programs to encourage you to use more cost-effective or clinically-effective drugs. This includes but is not limited to using Generic Drugs, home delivery 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 stop a program at any time. If you are participating in a program that We have stopped We will give you at least a 30 day advance written notice of the discontinuance.

You or your Doctor may order your Specialty Pharmacy Drug from the Specialty Pharmacy. A dedicated care coordinator will guide you or your Doctor through the process up to and including actual delivery of your Specialty Pharmacy Drug to you or your Doctor. When you order a Specialty Pharmacy Drug for home or Doctor 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 refills after that you will be contacted by your care coordinator.

Exception Process for Specialty Pharmacy Drugs

If you or your Provider believes 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 member services or at www.anthem.com.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Booklet. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

- Federally funded trials approved or funded by one of the following:
  - The National Institutes of Health.
  - The Centers for Disease Control and Prevention.
  - The Agency for Health Care Research and Quality.
  - The Centers for Medicare & Medicaid Services.
  - Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

    i The Department of Veterans Affairs.
    ii The Department of Defense.
    iii The Department of Energy.
- Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
- Studies or investigations done for drug trials which are exempt from the investigational new drug application.

We may require that you use an In-Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be investigational as defined by this Booklet. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to Our Clinical Coverage Guidelines, related policies and procedures.

We are not required to provide benefits for the following services. We reserve Our right to exclude any of the following services:

- The Investigational item, device, or service, itself; or
- Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

LIMITATIONS/EXCLUSIONS (What is Not Covered and Pre-Existing Conditions)

This section talks about the items that are not covered. The items here are not Covered Services under this Booklet. The list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. Just because a service is not mentioned below does not mean it will be covered. It is important to know that in the "Benefits/Coverage (What Is Covered)" section and in other parts of the Booklet there are limits, conditions, and exclusions which apply, even if not mentioned below. The list below is meant as an aid to show common items which are not covered.

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

1. That We find 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 Emergency Care and Urgent Care under the "Benefits/Coverage (What Is Covered)" section of this Booklet;
2. For care received from an Out-of-Network Provider, except for Emergency Care, Urgent Care or as preauthorized by Us as a Covered Service;
3. Received from someone or an entity that is not a Provider, as defined in this Booklet;
4. That are Experimental or Investigational or related to such, whether incurred before, in connection with, or subsequent to the Experimental or Investigational service or supply, as determined by Us;
5. That could be paid as benefits through any governmental unit (except Medicaid), unless otherwise required by law. The payment of benefits under this Booklet will be coordinated with such governmental units as required by state and/or federal laws;
6. For which benefits would be paid by Medicare Part A and/or Part B, unless otherwise stated in this Booklet or prohibited by federal law. See Medicare under the "General Policy Provisions" section of this Booklet;
7. In excess of the Maximum Allowed Amount unless otherwise stated in this Booklet;
8. Incurred before your Effective Date;
9. Incurred after the end date of this coverage unless otherwise stated in this Booklet;
10. For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Cosmetic Services have the intent to preserve, change or improve your appearance. Or they are for psychiatric or psychological reasons. There is no coverage for Surgery or treatments to change the texture or appearance of your skin. There is no coverage to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts) except where specifically required by law;
11. For services done to maintain or preserve the present level of function or prevent regression of function for a condition that is resolved or stable;
12. For Dental Services. Excluded dental services include, but are not limited to, preventive care and fluoride treatments; dental x-rays, supplies, appliances and all associated expenses; and diagnosis and treatment related to the teeth, jawbones or gums such as extraction (including dental prosthesis and any treatment for teeth, gums, tooth or upper or lower jaw augmentation or reduction (orthognathic Surgery), extraction of impacted wisdom tooth), restoration and replacement of teeth, and services to improve dental clinical outcomes. This exclusion does not apply to services which We are required by law to cover; services to prepare the mouth for radiation therapy to treat head and/or neck cancer; and services specified as covered in this Booklet;
13. Weight loss programs including treatment for obesity, whether or not they are under a medical or Doctor's care, unless otherwise stated in this Booklet;
14. For care you get in an emergency room which is not Emergency care;
15. For research studies or screening exams, unless otherwise stated in this Booklet;
16. For stand-by charges of a Doctor;
17. Shots for travel;
18. Routine exams and shots that are needed 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 Health Services or Hospice Care services under the "Benefits/Coverage (What Is Covered)" section of this Booklet;

20. Related to male or female sexual or erectile dysfunction or inadequacies, no matter what origin or cause. This includes all procedures, and equipment developed for or used in the treatment of impotency;

21. Nutritional and/or dietary supplements, unless otherwise stated in this Booklet or as required by law. This exclusion includes those nutritional formulas and dietary supplements that can be bought over the counter, which by law do not require either a written Prescription Drug or dispensing by a licensed pharmacist;

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 Doctor;

24. For services or supplies for Intractable Pain and/or Chronic Pain;

25. Services that are more than the Benefit Period maximum payments as listed in the Booklet or *Schedule of Benefits* even if you have satisfied the Out-of-Pocket Annual Maximum;

26. Breast reduction Surgery (reduction mammoplasty) or services related to it, except as required by law or We determine such services are Medically Necessary;

27. For any condition, disease, defect, ailment or injury arising out of and in the course of employment, except for officers of the company who have opted out of workers' compensation before the illness or injury. This exclusion applies even if some or all benefits in whole or in part under any Workers' Compensation Act or other similar law are not paid. This 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 stated in "General Policy Provisions" section of this Booklet;

28. For anything 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 testing or care that has been ordered by a court 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. That you get from a dental or medical department run 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 filling out claim forms or charges for medical records or reports, unless otherwise required by law;

35. For missed or canceled appointments;

36. For mileage or other travel costs, except if We approve it;

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. This includes, but not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails;

39. For marital counseling or personal growth;

40. For eyeglasses, contact lenses or their fitting, vision therapy or routine vision exams, unless otherwise stated in this Booklet;

41. For hearing aids, unless otherwise stated in this Booklet;

42. For services or supplies mainly for educational, vocational, or training purposes, unless otherwise stated in this Booklet;

43. Services to reverse voluntarily induced sterility;

44. Services of any type for the treatment of infertility;

45. 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);

46. For services (including speech therapy) for dysfunctions that are self correcting. This includes language therapy for young children with natural dysfluency or developmental articulation errors that are self correcting. It also includes learning and behavior problems, hyperkinetic syndromes or mental retardation (except for Prescription Drugs for treatment of these conditions if Prescription Drugs are covered);

47. For personal hygiene services, self help devices that are not medical in nature, or services and supplies for comfort and ease;

48. For care related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy;

49. Health club memberships, exercise equipment, charges from a fitness or personal trainer, or any other charges for physical fitness, even if ordered by a Doctor. This also applies to health spas;

50. For self help training and other forms of self care that are not medical in nature, unless otherwise stated in this Booklet;

51. For hair loss treatment, even if the hair loss is caused by a medical condition, except for alopecia areata or as otherwise stated in this Booklet;

52. For peripheral bone density scans;

53. For storage or other administrative costs, except when provided as part of the Inpatient Services and Human Organ and Tissue Transplant Services under the "Benefits/Coverage (What Is Covered)" section of this Booklet;

54. For medical, surgical services and appliances related to temporomandibular joint (TMJ) therapy regardless of Medical Necessity;

55. For the cost of donor sperm or donor eggs, storage costs for sperm or frozen embryos, or tests to see if a procedure to promote fertility or pregnancy is effective;

56. Provided or billed by a school, halfway house, or outward bound program, even if psychotherapy is included;

57. For rolfing therapy, myotherapy or prolotherapy;

58. Ambulance services when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor. Other non-covered Ambulance services include, but are not limited to, trips to Doctor's office, clinic, morgue or funeral home;

59. For Foot Orthotics, orthopedic shoes and arch supports (except if you are diagnosed with diabetes);

60. For air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, wristlets, augmentative communication devices, surgical supports, and corsets or other articles of clothing, unless otherwise stated in this Booklet;

61. For items most often stocked in the home for general use like Band-Aids, thermometers and petroleum jelly;

62. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for Cosmetic purpose;

63. For any services or supplies provided to a person not covered under the Booklet in connection with a surrogate pregnancy. This includes, but not limited to, the bearing of a child by another woman for a couple who cannot have a child;

64. Language training for delays in education, psychology or in speech;

65. Hobbies, arts and crafts that are a diversion, for recreation, or vocational in nature;

66. Cardiac Rehab home programs, which also includes on-going care;

67. Related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), biofeedback, chelating agents (except for treatment of heavy metal poisoning) and iridology;

68. For massage therapy;

69. For acupuncture/nerve pathway therapy mainly for the purpose of weight control, related to menstrual cramps and addiction including smoking cessation;

70. For phone or fax communications between a Provider and Member for Telemedicine;

71. For any of the following if done in connection with online visit services, such as reporting normal lab or other test results, office appointment requests, billing, insurance or payment questions, requests for referrals to Doctors outside the online care panel, benefit Preauthorization, and Doctor to Doctor consultation;

72. For smoking cessation programs to help you stop smoking if the program is not affiliated with Us; or

73. Providers that are not licensed by law to provide Covered Services, as defined by this Booklet.

Human Organ and Tissue Transplant Services:

1. Human organ and tissue transplant services that are not done by a In-Network transplant Provider for the organ or tissue being transplanted;

2. If you are not a suitable candidate as determined by the In-Network transplant Provider to provide human organ and tissue transplant services;

3. Benefits for services for donor searches or tissue matching, or personal living costs related to donor searches or tissue matching, for the recipient or donor, or for their family members or friends except as covered;

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 “Benefits/Coverage (What Is Covered)” section in this Booklet 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; or

8. For non-covered transportation and lodging costs related but not limited to the following:

    - Alcohol, tobacco, other non-food items;
    - Meals;
    - Child care;
    - Mileage within the medical transplant Facility city;
    - Rental car, buses, taxis, or shuttle services, except those that We approve;
    - Frequent flyer miles;
    - Coupons, vouchers, or travel tickets;
    - Prepayment or deposits;
    - Services for a condition that is not directly related, or a direct result, of the transplant;
    - Phone calls;
    - Laundry;
    - Postage;
    - Entertainment;
    - Interim visits to a medical care facility while waiting for the actual transplant procedure;
    - Travel costs for donor companion/caregiver;
    - Return visits for the donor for a treatment of an illness found during the evaluation.

Online Visits:

Non-Covered Services include, but are not limited to communications used for:

- Reporting normal lab or other test results;
- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to doctors outside the online care panel;
- Benefit precertification;
- Physician to Physician consultation

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, unless otherwise specified in this Booklet;
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. Drugs not approved by the FDA;
7. Any medications used to treat infertility;
8. Delivery charges for prescriptions;
9. Charges for the administration of any drug unless dispensed in the Doctor'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 "Benefits/Coverage (What Is Covered)" section;
13. Therapeutic devices or appliances, including support garments and other nonmedicinal supplies (regardless of intended use);
14. Certain Prescription Drugs may not be covered if you could use a Clinically Equivalent Drug, even if written as a prescription, unless required by law;
15. Over-the-counter items drugs, devices and products, or Prescription Drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product, even if written as a prescription. This includes Prescription Drugs when any version or strength becomes available over the counter. This Exclusion does not apply to over-the-counter products that We must cover under federal law with a Prescription;
16. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) except for injectable insulin, or where applicable law requires coverage of the drug;
17. Prescription Drugs, which are dispensed in quantities or refill frequency which exceed the applicable limits established by Us, at Our sole discretion;
18. Refills of prescriptions in excess of the quantity prescribed by the Provider, or refilled more than one year from the date prescribed;
19. Prescription Drugs dispensed for the purpose of international travel;
20. Prescription Drugs which have been obtained through a Home Health Agency;
21. Replacement of lost or stolen Prescription Drugs;

22. Drugs for treatment of sexual or erectile dysfunction or inadequacies, regardless of origin or cause and even if the dysfunction is a side effect of, or related to another covered disease or illness; or

23. When benefits are provided for Prescription Drugs under the Retail Pharmacy/Home Delivery Pharmacy Prescription Drugs section, they will not also be provided under the Prescription Drugs Administered by a Professional Provider section.

Specialty Pharmacy Drugs

1. When benefits are provided under the Specialty Pharmacy benefits they will not be provided under the "Benefits/Coverage (What Is Covered)" section of this Booklet, including without limitation Specialty Pharmacy Drugs administered by a medical Provider; or

2. 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.

Chiropractic Therapy

1. Services for preventive, maintenance or well care;

2. Drugs, vitamins, nutritional supplements or herbs;

3. Vocational, stroke, or long-term rehab unless otherwise stated in this Booklet;

4. Hypnotherapy, behavior training, sleep therapy, or biofeedback;

5. Rental or purchase of durable medical equipment unless otherwise stated in this Booklet;

6. Treatment for weight control;

7. Lab services;

8. Thermography, hair analysis, heavy metal screening of mineral studies;

9. Inpatient services;

10. Manipulation under Anesthesia;

11. Treatment of non-neuromusculoskeletal disorders; or

12. Advance diagnostic services such as MRI, CT, EMG, SEMG, and NCV.

Pre-existing Conditions

Not applicable, plan does not impose limitation period for pre-existing conditions.

MEMBER PAYMENT RESPONSIBILITY

Cost Sharing Requirements

Cost Sharing is how We share the cost of health care services with you. It means what We are responsible for paying and what you are responsible for paying. You meet your Cost Sharing requirements through your payment of Copayments and Coinsurance (as described below).

We work with Doctors, 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.

You are always liable for a Provider's full billed charge for any non-Covered Service, services that the exceed the Benefit Period Maximum and for services that are received for non-Emergency Care and non-Urgent Care, if received from an Out-of-Network Provider without Our authorization.

The contracts between Us and Our In-Network 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 Booklet.

Maximum Allowed Amount

This section describes how We determine what We pay for Covered Services. Reimbursement of Covered Services given to you by an In-Network Provider is based on your plan's Maximum Allowed Amount for the Covered Service that you receive. Please see Inter-Plan Programs in the "Claims Procedure (How to File a Claim)" and the BlueCard® Program in the "How to Access Your Services and Obtain Approval of Benefits" sections for more information.

The Maximum Allowed Amount for this plan is the maximum amount of reimbursement We will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under this Booklet and are not excluded;
- that are Medically Necessary; and
- that are provided with all applicable Preauthorization, utilization management or other requirements in this Booklet.

You will be required to pay a portion of the Maximum Allowed Amount for Covered Services which are subject to Coinsurance.

When you receive Covered Services from an In-Network Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you receive were not Medically Necessary. It means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this happens, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other Provider, We may reduce the Maximum Allowed Amounts for those secondary and later procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for parts of the primary procedure that may be considered incidental or inclusive.

Member Cost Share

For certain Covered Services, and depending on your health benefits plan, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount. For example you would need to pay for your Coinsurance.

Please see the *Schedule of Benefits* for your cost share amounts and limitations. You can also call member services to find out your health benefit coverage or cost share amounts which can vary by the type of Provider you use.

We will not pay for services that are not covered by this Booklet. You may be responsible for the total amount billed by your Provider for non Covered Services. Non Covered Services include services specifically excluded from coverage by the terms of this Booklet and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, the lifetime maximum, benefit caps or day/visit limits.

Under certain events, if We pay the Provider amounts that are your responsibility, such as Copayments or Coinsurance, We may get those amounts back from you. You agree that We have the right to collect such amounts from you.

Authorized Services

Services from Out-of-Network Providers are covered only under limited circumstances. Non-Emergency services from Out-of-Network Providers are not covered unless specifically authorized by Us before services are received.

In some cases, such as where there is no In-Network Provider available for the Covered Service, We may authorize the In-Network Cost Sharing amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you get from an Out-of-Network Provider. In such circumstance, you must contact Us in advance of getting the Covered Service. Please contact member services to request authorization.

Claims Review

We have processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services, or other services authorized by us according to the terms of this Plan from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

Copayment

Copayments may be required for Covered Services. A Copayment is a set, fixed-dollar amount you must pay to receive a specific service. You are required to pay your Copayments to Providers for specific Covered Service as listed in the *Schedule of Benefits*. You need to pay Copayments directly to the Provider. Copayments are included in the Out-of-Pocket Annual Maximum.

Your Copayment may be higher for a Specialist than for a Primary Care Provider. The Copayment amounts are listed in the *Schedule of Benefits*.

Out-of-Pocket Annual Maximum

The Out-of-Pocket Annual Maximum is designed to protect you from catastrophic health care costs. Once you and/or your family have satisfied the Out-of-Pocket Annual Maximum, We pay 100 percent of any remaining eligible changes for the rest of your Benefit Period. The Out of Pocket Annual Maximum is found on the *Schedule of Benefits*.

Family Out-of-Pocket Annual Maximum - The family Out-of-Pocket Annual Maximum is a combined Out-of-Pocket Annual Maximum. This means any combination of amounts paid by family Members toward Covered Services can be used to satisfy the family Out-of-Pocket Annual Maximum. One person may not contribute more than the individual Out-of-Pocket Annual Maximum toward the family Out-of-Pocket Annual Maximum.

The Family Membership Out-of-Pocket Annual Maximum is also applicable for newborn and adopted children for the first 31-day period following birth or adoption if the child is enrolled or not enrolled following the 31-day period.

Benefit Period Maximum

Some Covered Services have a maximum benefit 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 *Schedule of Benefits* for those services which have a Benefit Period Maximum.

If you leave this plan, and go on to a new plan with Us in the same Benefit Period, all covered benefits that have a Benefit Period maximum or lifetime maximum will be carried over to the new plan. For instance, 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 plan for the same benefit until the Benefit Period ends, as benefits have been exhausted for your Benefit Period.

CLAIMS PROCEDURE (How to File a Claim)

When an In-Network Provider bills Us for Covered Services, We will pay the charges for the benefit directly to the Provider. You are responsible for giving the In-Network Provider all the information needed for them to submit a claim. You pay a Copayment and Coinsurance to the Provider when you get a Covered Service.

If an Out-of-Network Provider does not bill Us directly, you must file the claim. To get claim forms, call Our member services or print it from Our website at www.anthem.com. If We do not give you a claim form within 15 days of your request, you may submit written proof of the claim and will be considered to have complied with the rules of this Booklet 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 dollar. To find out the dollar 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 has detailed instructions on how to complete the form and what information is needed.

We pay the benefits of this Booklet directly to Out-of-Network Providers, depending on whether you have authorized an assignment of benefits. 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 for all charges. These payments fulfill Our obligation to you for those services.

A separate claim form is required for each Out-of-Network Provider for which you are requesting payment.

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

Where and When to Send Claims - A claim must be filed **within 180 days** after the date of service. Any claims filed after this limit may be refused. But if you can show that it wasn't possible to file within this time limit, and that you filed your claim promptly afterwards, then We will not consider the claim late.

Claims will be processed in the time frame required by any state law for the prompt payment of claims which applies to this Booklet.

You should make copies of the bills for your own records and attach the original bills to the filled out claim form. Submit your bills and claim form to:

HMO Colorado Claims
P.O. Box 5747
Denver, CO 80217-5747

If you die, any claims payable to you will be paid to your beneficiary or your estate. If the Provider is a In-Network Provider, claim payments will be made to the Provider.

Payment in Error - If We make a payment error, We may require you, the Provider or the ineligible person to give back the amount paid in error.

Inter-Plan Programs

Out-of-Area Services - HMO Colorado has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of HMO Colorado's Service Area, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside HMO Colorado's Service Area and the Service Area of HMO Colorado's corporate parent, you will obtain care from healthcare Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare Providers. HMO Colorado's payment practices in both instances are described below.

HMO Colorado covers only limited healthcare services received outside of HMO Colorado's corporate parent's Service Area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency care or urgent care obtained outside the geographic area HMO Colorado's corporate parent serves. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by your Primary Care Provider ("PCP").

BlueCard® Program - Under the BlueCard® Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, HMO Colorado will remain responsible for fulfilling HMO Colorado's contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare Provider participating with a Host Blue, where available. The participating healthcare Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment amount, as stated in your Booklet.

Emergency Care Services - If you experience a medical Emergency while traveling outside the HMO Colorado Service Area, go to the nearest Emergency or Urgent Care Facility.

Whenever you access covered healthcare services outside HMO Colorado's and, if applicable, HMO Colorado's corporate parent's Service Area, and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to HMO Colorado.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price HMO Colorado uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, We would then calculate your liability for any covered healthcare services according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation - When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare Provider bills and the payment We will make for the Covered Services as set forth in this paragraph.

Exceptions - In certain situations, We may use other payment bases, such as billed covered charges, the payment We would make if the healthcare services had been obtained within Our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount We will pay for services rendered by nonparticipating healthcare Providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare Provider bills and the payment We will make for the Covered Services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a Provider who is not part of an exclusive network arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the member service number on your Health Benefit ID Card for more information about such arrangements.

GENERAL POLICY 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 Booklet - For employer groups of one to 50, if We amend this Booklet to change 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 Employer Master Contract.

For all other changes, such as changes due to state or federal law or regulation, We may amend this Booklet 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 later send or make available to you an amendment to this Booklet or a new Booklet.

No agent or employee of Ours may change this Booklet by giving information that is not correct or complete, or by contradicting the terms of this Booklet. Any such situation will not prevent Us from administering this Booklet in strict accordance with its terms. Oral or written statements do not replace the terms of this Booklet.

Conformity with Law - any term in this Booklet which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contracting Entity - You acknowledge that you understand that the Booklet 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 Booklet. This paragraph does not create any additional obligations whatsoever on Our part other than those obligations created under other provisions of the Booklet.

Decision Makers - In some case, We will recognize others as surrogate decision-makers to make decisions related to your 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 against the law to knowingly provide false, incomplete or misleading facts or information to an insurance company for 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 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, Deductible and/or Coinsurance. 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 member services; and
- Be very cautious about giving your health insurance coverage information over the phone.

If fraud is suspected, you should contact Our member services.

We reserve the right to recoup any benefit payments paid on your behalf, and/or rescinding your membership under this Booklet 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 In-Network Providers. Doctors and other Providers are not Our agents or employees, and We and Our employees are not employees or agents of any of Our In-Network Providers. We have no control over any diagnosis, treatment, care or other service given 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 connected with, any injuries you suffer while receiving care from any of Our In-Network Providers by reason of neglect 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 are experts in certain areas. This may include Prescription Drugs, Mental Health Condition and Substance Abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims payment or member services duties on Our behalf.

Member's Duty to Give Information and Cooperate - You must give Us information We will need to decide if services are covered under this Booklet. We will also need information to carry out the other terms of this Booklet.

You agree to cooperate at all times, even when you are in a hospital. This is done by allowing Us to see your medical records to review claims and confirm information you gave in your enrollment application, change form, 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 end your coverage.

Medicare - Any benefits covered under both this Booklet 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 when there is a conflict among state law, Booklet provisions, and federal law. Except when federal law require Us to be the primary payor, the benefits under this Booklet 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 paid 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 networks in Colorado that 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 member services. This document is also available on Our website or for in-person review at 700 Broadway in Denver, Colorado, in the member services.

Non-Contestable - This Booklet shall not be contested, except for nonpayment of Premium 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 Booklet 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 Booklet 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 given to the Member making the statement or to the beneficiary of any such Member.

Notice of Privacy Practices - We promise to protect the private 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 or contact Our member services.

No Withholding of Coverage for Necessary Care - We do not pay, reward or incent, financially or otherwise, Our associates for inappropriate restrictions of care. We do not promote or otherwise provide a reward to employees or Doctor reviewers for withholding benefit approval for Medically Necessary Covered Services to which you are entitled. Utilization Review and benefit coverage decision making is based on appropriate care and service and the terms of this Booklet.

We do not design, calculate, award or permit financial or other rewards based on the frequency of: denials of authorization for coverage; reductions or limitations on Hospital lengths of stay, medical services or charges; or phone calls or other contacts with you or your Provider.

Paragraph Headings - The headings used in this Booklet are for reference only and are not to be used by themselves for interpreting the terms of the Booklet.

Physical Examinations and Autopsies - We have the right, 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 allowed by law.

Research Fees - We reserve the right to charge an administrative fee when a lot of research is necessary to reconstruct information that has already been given 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.

Right of Overpayment Recovery - When payment has been made in error, We will have the right to recover such payment from you or the Provider. In the event We recover a payment made in error from the Provider, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider, except in cases of fraud or where the law specifies a different period of time in which to recover payment. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, vendor, or Subcontractor resulting from these audits if the return of the overpayment is not likely.

We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the Recovery method makes providing such notice administratively burdensome.

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; or
- The Subscriber's employer.

Statement of ERISA Rights - The group health care coverage provided by the employer may be offered as part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Members shall be entitled to:

Receive Information About the Coverage and Benefits.

All plan Members may:

- Examine, without charge, at the plan administrator's office or other specified locations, all documents governing the coverage and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies; and
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each Member with a copy of this summary annual report.

In addition to creating rights for plan Member, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in your interest as well as in the interest of the Subscriber and other plan Members and beneficiaries. No one, including the Subscriber's employer, or any other person, may fire the Subscriber or otherwise discriminate against the Subscriber in any way to prevent him/her from getting a welfare benefit or exercising rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules. You must follow the procedures set forth in the "Appeals and Complaints" section.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, after having exhausted the procedures set forth in the "Appeals and Complaints" section. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court. The court will decide whom, if

anyone should pay court costs and legal fees. If you are successful the court may order the other party(ies) to pay these costs and fees. If you should lose, the court may order you to pay these costs and fees.

Assistance with Questions

If you have any questions about the plan, or whether it is a plan governed by ERISA you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the phone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

This benefit plan gives the plan administrator or fiduciary discretionary authority to determine eligibility for benefits and to construe the terms of the Booklet. The plan specifically reserves to the plan administrator or fiduciary the discretion and authority to make such determinations, but where required by applicable law, Our determination may be reviewed de novo (as if for the first time) in a later appeal or legal action. We serve as a claims fiduciary, not as the administrator of your employer's plan. You should contact your employer to find out who is the plan administrator.

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 due to illness or injury related to your work are not a benefit under this Booklet, except for officers of the company who have opted out of workers' compensation before the illness or injury. This exclusion from coverage applies to costs due from occupational accident or sickness covered under the following:

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

We will not pay benefits for services and supplies due to illness or injury related to your work even if other benefits are not paid because:

- You fail to file a claim within the filing period allowed by law;
- You get care that is not approved 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 illness or injury costs related to your work; or
- You fail to follow any other terms of the Workers' Compensation Act.

Automobile Insurance Provisions

We will coordinate the benefits of this Booklet with the benefits of a complying auto insurance policy.

A complying automobile insurance policy is an auto 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 et seq. Any state or federal law requiring similar benefits through legislation or regulation is also considered a complying auto policy.

How We Coordinate Benefits with Auto Policies - Your benefits under this Booklet may be coordinated with the coverage's afforded by an auto policy. After any primary coverage's offered by the auto policy are exhausted, including without limitation any no-fault, personal injury protection, or medical payment coverages, We will pay benefits subject to the terms and conditions of this Booklet. If there is more than one auto policy that offers primary coverage, each will pay its maximum coverage before We are liable for any further payments.

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

We may require proof that the auto policy has paid all primary benefits before making any payments under this Booklet. On the other hand, We may but are not required to pay benefits under this Booklet, and later coordinate with or seek reimbursement under the auto policy. In all cases, upon payment, We are entitled to exercise Our rights under this Booklet and under applicable law against any and all potentially responsible parties or insurers. In that event, We may exercise the rights found in this section.

What Happens If You Do Not Have Another Policy - We will pay benefits if you are injured while you are riding in or driving a motor vehicle that you own if it is not covered by an auto policy.

Similarly if not covered by an auto policy, We will also pay benefits for your injuries if as a non-owner or driver, passenger or when walking you were in a motor vehicle accident. In that event, We may exercise the rights found in this section.

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) agree 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. Reimbursement or subrogation under this Booklet may only be permitted if you have been fully compensated, and, the amount recoverable by Us may be reduced by a proportionate share of your attorney fees and costs, if state law so requires.

Subrogation

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

- If you have been fully compensated, We have a lien against all or a portion of the benefits that have been paid to you from the following parties, 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. However, Our Recovery cannot exceed the amount actually paid by Us under your policy as it relates to the injuries or illness that are the subject of the subrogation action; and

- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them. If you have not pursued a claim against a third party allegedly at fault for your injuries by the date that is sixty (60) days before to the date on which the applicable statute of limitations expires, We have a right to bring legal action against the at-fault party.

Right of Reimbursement

If you, a person who represents your legal interest, or beneficiary have been fully compensated and We have not been repaid for the health insurance benefits We paid on the Member's behalf, We shall have a right to be repaid from the Recovery in the amount of the health insurance benefits We paid on your behalf and the following apply:

- You must reimburse Us to the extent of the health insurance 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 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 reimbursement; and

- You, a person who represents your legal interest, or beneficiary must hold in trust for Us right away the amount recovered in gross that is to be paid to Us. The amount recovered in gross is the total amount of your Recovery reduced by your lawyer fees and costs.

The Member's Duties

- You, a person who represents your legal interest, or beneficiary must tell Us right away the how, when and where an accident or event that resulted in your injury or illness. We must find out what happened and get all the details about the parties involved;
- You, a person who represents your legal interest, or beneficiary must work with Us in investigating, settling and protecting rights;
- You, a person who represents your legal interest, 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, a person who represents your legal interest, or beneficiary must promptly notify Us if you retain an attorney or if a lawsuit is filed;
- If you, a person who represents your legal interest, or beneficiary gets a Recovery that is less than the sum of all your damages incurred by you, you are required to tell Us within 60 days of your receipt of the Recovery. The notice to Us must include:
  - Total amount and source of the Recovery;
  - Coverage limits applicable to any available insurance policy, contract or benefit plan; and
  - The amount of any costs charged to you.
- If We receive your notice that you have not been fully paid, We have the right to dispute that determination;
- If We dispute whether your Recovery is less than the sum of all your damages, such dispute must be resolved through arbitration; and
- If you, a person who represents your legal interest, or beneficiary resides in a state where automobile personal injury protection or medical payment coverage is mandatory, that coverage is primary and the Booklet takes secondary status. The Booklet will reduce benefits for an amount equal to, but not less than, that state's mandatory minimum personal injury protection or medical payment requirement.

Duplicate Coverage and Coordination of Benefits

We may coordinate benefits when you have coverage with more than one health coverage.

Duplicate Coverage - Duplicate coverage is the term used to describe when you are covered by this coverage and also covered by another:

- Group or group-type health insurance;
- Health 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.

Order of Benefit Determination Rules – The following rules are used in the order as listed:

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 plan that does not have order of benefit determination rules will always be primary unless the provisions of both plans state that the plan is primary.

Non-Dependent or Dependent

The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person, as a dependent, is secondary. If the person is a Medicare beneficiary, please refer to the section below of "Determining Primacy Between Medicare and Us" for primary and secondary payer rules.

Active Employee, Retired or Laid-Off Employee

a. The plan that covers a person as an active employee, who is not laid off or retired, or a dependent of an active employee, is the primary plan.

b. If the secondary, or other plan, does not have this rule, and as result the plans do not agree on the order of benefits, this rule is ignored.

c. This rule does not apply if the section above of “Non-Dependent or Dependent” can determine the order of benefits.

COBRA or State Continuation Coverage

a. If a person whose coverage is provided in accordance with COBRA, or under a right of continuation according to state or federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree, is the primary plan and the plan covering that same person in accordance with COBRA, or under a right of continuation in accordance with state or other federal law, is the secondary plan.

b. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

c. This rule does not apply if the section above of “Non-Dependent or Dependent” can determine the order of benefits.

Longer or Shorter Length of Coverage

a. If the rules above do not determine the order of benefits, the plan that covered the person for the longer period of time is primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

b. To determine the length of time a person has been covered under a plan, two (2) successive plans will be treated as one if the covered person was eligible under the second within twenty-four (24) hours after the first ended.

c. The start of a new plan does not include:

   (1) A change in the amount or scope of a plan’s benefits;

   (2) A change in the entity that pays, provides or administers the plan’s benefits; or

   (3) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

d. The person’s length of time covered under a plan is measured from the person’s first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person’s coverage under the present plan has been in force.

If none of the rules above determine the primary plan, the allowable expenses will be shared equally between the plans.

Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, plans covering a dependent child will determine the order of benefits as follows:

a. For a dependent child whose parents are married or are living together, whether or not they have been married:

   (1) The plan of the parent whose birthday falls earlier in the calendar year, by month and day, is the primary plan; or

   (2) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

   (1) If the court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no health care coverage for the dependent child’s health care, but that parent’s spouse does, the spouse’s plan is primary. This item will not apply with respect to a plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

   (2) If the court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, paragraph a above will determine the order of benefits;

   (3) If the divorce decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the depend child, paragraph a above will determine the order of benefits; or

(4) If there is no court decree allocating responsibility for the child's health care expenses of health care coverage, the order of benefits for the child are as follows:

(a) The plan of the custodial parent;

(b) The plan of the spouse of the custodial parent;

(c) The plan of the noncustodial parent; and then

(d) The plan of the spouse of the noncustodial parent.

c. For a dependent child covered under more than one plan of individuals who are not parents of the child, the order of benefits will be determined, as applicable, according to paragraph a. or b. above as if those individuals were the parents of the child.

d. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in the section above for "Longer or Shorter Length of Coverage" applies.

In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits will be determined by applying the birthday rule to the dependent child's parent(s) and the dependent's spouse.

Rules for Coordination of Benefits

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

1. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.
2. If the primary plan is a Closed Panel Plan, and the secondary plan is not a Closed Panel Plan, the secondary plan will pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary provider.
3. When multiple contracts providing coordinated coverage are treated as a single plan, this section only applies to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts.
4. If a person is covered by more than one secondary plan, each secondary plan will take into consideration the benefits of the primary plan, or plans, and the benefits of any other plan, which, has its benefits determined before those of that secondary plan.
5. Under the terms of a Closed Panel Plan, benefits are not payable if the covered person does not use the services of a closed panel provider, with the exceptions of medical emergencies and if there are allowable benefits available. In most instances, Coordination of Benefits does not occur if a covered person is enrolled in two (2) or more Closed Panel Plans and obtains services from a provider in one of the Closed Panel Plans because the other Closed Panel Plan (the one whose providers were not used) has no liability. However, Coordination of Benefits may occur during the claim determination period when the covered person receives emergency services that would have been covered by both plans.

Determining Primacy Between Medicare and Us - We will be the primary payer for persons with Medicare age 65 and older if the policyholder is actively working for an employer who is providing the policy holder's health insurance and the employer has 20 or more employees. Medicare will be the primary payer for persons with Medicare age 65 and older 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 enrolled with Medicare under age 65 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 in 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 with Medicare under age 65 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. But this will only apply if the group health coverage was primary at the point when the second entitlement took effect, for the

duration of 30 months after becoming Medicare entitled or eligible 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 - Based on the primacy rules, if Medicare is secondary to a group coverage (see Medicare primacy rules), the primary coverage covering the Member will pay first. Medicare will then 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 policyholder of the group health insurance.

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.

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 paid by that coverage, whether or not a claim is made. It also includes benefits that would have been paid but were refused. This is due to the claim not being sent to the Provider of other coverage on a timely basis.

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

Our Rights to Receive and Release Necessary Information – We may release to, or obtain, from any insurance company or other organization or person any information which We may need to carry out the terms of this Booklet. Members will furnish to Us such information as may be necessary to carry out the terms of this Booklet.

Payment of Benefits to Others - When payments that should have been made under this Booklet were 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 Booklet, and with that payment We will fully satisfy Our liability under this provision.

Duplicate Coverage and Coordination of Benefits 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 in whose behalf, the payments were made.

TERMINATION/NONRENEWAL/CONTINUATION

Active Policy Termination

Your coverage ends when one of the following happens:

- On the date the Employer Master Contract between the employer and Us ends;
- On the Subscriber's death;
- When the Premium has not been paid;
- When you or your employer commits fraud or intentional misrepresentation of material fact;
- When you are no longer eligible under the terms of the Employer Master Contract;
- When your employer gives Us written notice that you are no longer eligible. Coverage will end on the date of the notice 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 notice to end coverage for any Member. Coverage will end at the end of the month following the notification period or at the end of the month of the qualifying event. We will credit Premium paid in advance unless We do not receive the cancellation request at least 31 days before the Effective Date of the cancellation;
- When you move and because of that move you no longer reside or work within the Service Area. The exception to this is if you are continuing coverage under COBRA continuation. You must notify Us within 31 days of such a change in location. Coverage will end on the last day of the month in which the change of residence is reported; until that time, the only out-of-area services covered will be Emergency care and Urgent care. Non-Emergency care will not be covered;
- If you do not notify Us of a change of residence or workplace to an area outside Our Service Area, and We later become aware of the change, your coverage may be terminated back to the date of the change of residence or place of employment. You will have to pay Us and/or the Providers for Our payment for any services covered in error; or
- When We cease operations.

Dependent Coverage Termination

To remove a Dependent from coverage, you must send Us an enrollment application and change form 31 days before the Effective Date of the change. If We receive this 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 Premium paid in advance unless We do not get 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 cancelled Dependent in the period for which the credit would 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. It may also end when one of the following happens:

- At the end of the month when you notify Us in writing to cancel coverage for a Dependent;
- When the Dependent no longer qualifies as a Dependent. Such a Dependent has the right to seek COBRA or state continuation coverage;
- On the date of a final divorce decree or legal separation for a spouse. Such a Dependent has the right to seek COBRA or state continuation coverage;
- If you are a partner to a civil union or other relationship recognized as a spousal relationship in the state where the Subscriber resides, on the date such union or relationship is revoked or terminated. Also, if there is coverage for designated beneficiaries, on the date a Recorded Designated Beneficiary Agreement is revoked or terminated. In either case, such a Dependent does not have the right to seek COBRA continuation coverage, but will be eligible for state continuation benefits, subject to the terms of this Booklet; or
- At the end of the month when legal custody of a child placed for adoption ends.

What We Will Pay for After Termination

Except as stated below, We will not pay for any services given to you after your coverage ends even if We preauthorized the service, unless the Provider confirmed your 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 ended.

When your coverage ends for any reason other than for nonpayment of Premium, fraud or abuse, We will continue coverage if you are being treated at an inpatient facility, until you are discharged or transferred to another level of care. This is subject to the terms of this Booklet. The discharge date is seen as the first date on which you are discharged from the facility or transferred to another level of care. We will not cover the services you get after your discharge date.

Unless a law requires, We do **not** cover services after your date of termination even if:

- We approved the services; or
- 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 you take time off from work pursuant to the Family and Medical Leave Act, health insurance stays in force but you may be required to keep paying your share of the Premium. You may contact your employer for details.

State Continuation Eligibility and Notification

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

- Your termination of employment. To qualify, you must have been covered by the employer's group health coverage for at least (6) six straight months;
- Your reduction in working hours which results in loss of coverage. Reduction in working hours would include circumstances resulting from economic conditions, injury, disability, or chronic health conditions;
- Your death; or
- Divorce, legal separation, or civil union status of you and the spouse.

State Continuation Coverage Notification - Unless termination or reduction in working hours is the qualifying event, a Subscriber, spouse or Dependent child must tell the employer of their choice to keep coverage within 30 days after being eligible. The employer is responsible for telling the Subscriber, spouse and/or Dependent child of how to choose state continuation. Once the employer has given notice to the Subscriber, spouse and/or Dependent child, We must get timely notice from the employer that you want state continuation. We must also get timely payment of Premiums from the employer when paid by the Subscriber.

We should get the notice from the employer and your first no later than 30 days after the qualifying event. If the employer fails to give timely notice to you of your rights, this deadline may extend to 60 days after the qualifying event. For more, contact your employer.

COBRA Eligibility and Notification

COBRA Eligibility - For employers with 20 or more employees, Subscribers and their Dependent who lose eligibility with a group may keep coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). You should call the employer for more details. COBRA coverage can last for 18, 29 or 36 months. The length of time you can have depends on the qualifying event(s) and only if the federal rules 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; or
- 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 ended or within 60 days after the coverage ended, due to one of the qualifying events above, and the employee or Dependent is still disabled when the 18-month continuation period ends.

COBRA coverage is available to Dependents for 36 months from the date of the following qualifying events for:

- The surviving spouse and surviving children of a covered employee, when the covered employee dies;
- Spouse and Dependents of a covered employee, when the employee becomes eligible for Medicare in the 18 months before the qualifying event;
- Spouse and Dependent children of a covered employee, when the employee and the Spouse separate or divorce; or
- Dependent children of the covered employee, when they lose status 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 set the length of the continuation period for the newborn or adoptee.

COBRA Notification - Unless termination or reduction in hours is the qualifying event, a Subscriber, spouse, or Dependent child must tell the employer they want eligibility for COBRA coverage within 60 days of being eligible. Once the employer has given notice to the Subscriber, spouse and/or Dependent child of the right to get COBRA, We must get notice from them that you want COBRA coverage. We must also get payment of fees or Premiums for you to get on COBRA.

You have 60 days from the receipt of the employer notice or from the date the prior coverage would otherwise end, whichever is later, to tell the employer you want COBRA. To apply for COBRA, you must complete a COBRA or State Continuation of Coverage Application. The employer must complete their section, sign it, and send it to Us. After choosing COBRA, you must pay the first fees or Premiums due within 45 days. For more details, please call the employer.

Termination of State Continuation Coverage or COBRA

Your continuation coverage ends when the continuation period ends.

Continuation coverage may end before the continuation period ends if:

- The Employer Master Contract between Us and the employer ends. If the employer gets other group coverage, continuation coverage will continue under the new plan;
- You fail to pay Premium timely;
- Under state continuation coverage, you are eligible for another group health plan unless the other plan does not cover something that is covered by the continuation coverage. In that case, the state continuation coverage lasts until the continuation period ends or the other plan covers the excluded condition;
- Under state continuation coverage, the date the Recorded Designated Beneficiary Agreement is revoked or terminated, if it applies;
- Under COBRA coverage, you are covered by another group health plan unless the other coverage does not cover something that is covered by the COBRA coverage. In that case, the COBRA coverage lasts until the COBRA period ends or the other plan covers the excluded condition;
- The date the spouse remarries and becomes eligible for coverage under the new spouse's group health plan;
- Under COBRA coverage, you get Medicare;
- Your COBRA coverage was extended to 29 months and you are determined under the Social Security Act to no longer be disabled; or
- You tell Us in writing to cancel.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

APPEALS AND COMPLAINTS

We want your experience with Us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your health benefit plan or a service you have received. In those cases, please contact member services by calling the number on the back of your Health Benefit ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of the complaint, you have the right to file a complaint, appeal or grievance, which is defined below.

We may have turned down your claim for benefits. We may have also denied your request to preauthorize or receive a service or a supply. If you disagree with Our decision you can:

1. File a complaint;
2. File an appeal; or
3. File a grievance.

Complaints

If you want to file a complaint about Our member service or how We processed your claim, please call member services. A trained staff member will try to clear up any confusion about the matter. They will also try to resolve your complaint. If you prefer, you can send a written complaint to this address:

HMO Colorado
Member Services Department
P.O. Box 17549
Denver, CO 80217-0549

If your complaint isn't solved either by writing or calling, or if you don't want to file a complaint, you can file an appeal. We'll tell you how to do that next, in the Appeals section below.

Note: More details on the complaints and appeals process and time periods can be found in the Appeals Guide. You may get a copy of the Appeals Guide by visiting www.anthem.com or you can call member service.

Appeals

If We have denied a claim that you feel should have been covered, or handled in a different way, or had your coverage cancelled retroactively for a reason that is not because of your failure to pay premiums, you can file an appeal. You can appeal a denial that was made by Us before the service is received. You can also appeal a denial on a service after it is received. While We encourage you to file an appeal within 60 days of the unfavorable benefit determination, the written or oral appeal must be received by Us within 180 days of the unfavorable benefit determination. We will assign an employee to help you in the appeal process. An appeal can be filed verbally by calling member service.

An appeal can be filed by writing to this address:

HMO Colorado
Attn: Grievance and Appeals Department
700 Broadway
Denver, CO 80273

You don't have to file a complaint before you file an appeal. In your appeal, please state as plainly as possible why you think We shouldn't have denied your claim for benefits. Include any documents you didn't submit with the original claim or service/supply request. Also send any other documents that support your appeal. You don't have to file the appeal yourself. Someone else, like your Doctor or another representative, can file an appeal for you. Just let Us know in writing who will be filing the appeal for you.

The appeals process allows you to request an internal appeal, and in certain cases, an independent external appeal.

Internal Appeals

We have an internal process that We follow when reviewing your appeal. Members of Our staff, who were not involved when your claim was first denied, will review the appeal. They may also talk with co-workers to assist in the review.

If your first internal appeal is denied, you can ask for a second level appeal. But you don't have to file a second level appeal with Us before requesting an independent external review appeal or pursuing legal action.

Expedited internal appeal - If you have an urgent case, you may request that your internal appeal be reviewed in a shorter time period. This is called an expedited internal appeal. You or your representative can ask for an expedited

appeal if you had Emergency services but haven't been discharged from the Facility. Also, you can ask for an expedited appeal if the regular appeal schedule would:

- Seriously jeopardize your life or health;
- Jeopardize your ability to regain maximum function;
- Create an immediate and substantial limitation on your ability to live independently, if you're disabled; or
- In the opinion of a Doctor with knowledge of your condition, would subject you to severe pain that can't be adequately managed without the service in question.

Independent External Appeals

For claims based on Utilization Review, you can request an independent external appeal. Utilization review includes claims We denied as Experimental or Investigational or not Medically Necessary. It also includes claims where We reviewed your medical circumstances to decide if an exclusion applied. For these appeals, your case is reviewed by an external review entity, selected by the Colorado Division of Insurance.

Your request for independent external review must be made within 4 months of receiving Our appeal decision. Generally, you have to have completed at least the first level internal appeal. But if We fail to handle the appeal according to applicable Colorado insurance law and regulations, you will be eligible to request independent external review.

Expedited external appeal - You or your representative can request an expedited independent external review, but only in certain cases.

- You had Emergency services but haven't been discharged from the Facility;
- You will need a Doctor to certify to Us that you have a medical condition where following the normal external review appeal process would seriously jeopardize your life or health, would jeopardize your ability to regain maximum function or, if you're disabled, would create an imminent and substantial limitation of your ability to live independently; or
- We denied coverage for a requested medical service as being Experimental or Investigational, your treating Doctor certifies in writing that the requested service would be significantly less effective if not promptly initiated and certifies that either:
  - Standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you; or
  - The Doctor is a licensed, board-certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition, there is no available standard health care service or treatment covered by this Booklet that is more beneficial than the requested service, and scientifically valid studies using accepted protocols demonstrate that the requested service is likely to be more beneficial to you than any available standard services.

If it meets these conditions, your request for expedited external appeal can be filed at the same time as your request for an expedited internal appeal.

For more information on where and how to request an internal or external appeal, please consult the Appeals Guide available at www.anthem.com, or call member service.

Grievances

If you have an issue or concern about the quality or services you receive from a In-Network Provider or Facility, you can file a grievance. The quality management department strives to resolve grievances fairly and quickly.

You may call member service or send a written grievance to:

HMO Colorado
Attn: Grievance and Appeals Department
700 Broadway
Denver, CO 80273-0001

Our Quality Management Department will acknowledge that We've received your grievance. They'll also investigate it. We treat every grievance confidentially.

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 Booklet 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 member services. 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. If 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 found in this section. You must meet all the requirements of this Booklet.

No action in law or in equity shall be brought to recover on this Booklet before the expiration of 60 calendar days after a claim has been filed according to the requirements of this Booklet. If you have exhausted all mandatory levels of review in your appeal, you may be entitled to have the claim decision reviewed de novo (as if for the first time) in any court with jurisdiction and to a trial by jury.

No such action shall be brought at all unless brought within three years after claim has been filed as required by the Booklet.

INFORMATION ON POLICY AND RATE CHANGES

Insurance Premiums

How Premiums are Established and Changed - Premiums are the monthly charges you and/or the employer must pay Us to get coverage. We figure out and set 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 have you contribute to the Premium cost through payroll deduction. Some employer groups may choose to have your Premium determined by the age of the Subscriber, with Premium set by age brackets. We may change membership Premiums on the Anniversary Date, which We may assess when a Subscriber changes to a new five-year increment age bracket, e.g., age 25 through age 29. If the age of the Subscriber is misstated at enrollment, all amounts payable for the correct age will be adjusted and billed to the group.

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 Booklet.

DEFINITIONS

This section defines words and terms used throughout the Booklet to help you learn the content. The first letter of each of these words will be capitalized when used in this Booklet. You should refer to this section to find out exactly how a word or term is used for the purposes of this Booklet.

Accidental Injuries - unintentional injuries inside or outside your body, for example strains, animal bites, burns, contusions and abrasions which result in trauma. Accidental Injuries are different from beings sick.

Acute Rehab Therapy - Inpatient Rehab Therapy for a short period of time. Acute rehab therapy services are not the same as acute hospital medical or surgical care.

Alcoholism Treatment Center - a Hospital or Facility, licensed by the Colorado Department of Human Services, providing services especially for the treatment of Alcohol and Substance Dependency.

Alternative Care - therapeutic practices that are not currently considered an integral part of conventional medical practice.

Alternative Care Facility - a health care facility which is not a hospital, or an attached facility assigned as free standing by a Hospital which mainly provides outpatient services such as:

- Diagnostic services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
- Surgery; and
- Therapy services or rehab.

Ambulance - a licensed vehicle used **only** for transporting you if you are sick or injured. It must have safety and lifesaving equipment such as first-aid supplies and oxygen equipment. The vehicle must be operated by trained staff.

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

- General Anesthesia, also known as total body Anesthesia, puts you to sleep for a period of time; or
- 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 your employer renews its coverage.

Applied Behavior Analysis - the use of behavior analytic methods and research findings to change socially important behaviors in meaningful ways.

Autism Services Provider - a person who provides services to a Member with Autism Spectrum Disorders. The Provider must be licensed, certified, or registered by the applicable state licensing board or by a nationally recognized organization, and who meets the requirements as defined by state law:

Autism Spectrum Disorders or ASD - includes the following neurobiological disorders: autistic disorder, Asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified, as defined in the most recent edition of the diagnostic and statistical manual of mental disorders, at the time of the diagnosis.

Autism Treatment Plan - a plan for a Member by an Autism Services Provider and prescribed by a Doctor or psychologist in line with a evaluating or again reviewing a Member's diagnosis; proposed treatment by type, frequency, and expected treatment; the expected outcomes stated as goals; and the rate by which the treatment plan will be updated. The treatment plan is in line with the patient-centered medical home as defined in state law.

Benefit Period - Your Benefit Period is based on a calendar year and begins on the Subscriber's Effective Date, and end on the following December 31; a new Member's Benefit Period starts on each January 1 that follows. If your coverage ends earlier, the Benefit Period ends at the same time.

Billed Charges - a Provider's regular charges for services and supplies as offered to the public and without any adjustment for In-Network Provider or other discounts.

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

Booklet - this book, sometimes called a certificate, and any amendments or riders, which explains what is covered, what is not covered, and other terms of your health plan.

Cardiac Rehab - medically supervised program to resume your activities of daily living after a heart attack.

Care Management - a plan of Medically Necessary health care that best meets your needs.

Chronic Pain - pain that lasts more than six months that is not life threatening, and it may continue for a lifetime, and has not responded to current treatments.

Chronic Rehab Therapy - a non-acute Inpatient Rehab Therapy that last for more than six months and may continue for a lifetime.

Clinically Equivalent - means drugs as determined by Us that, for the majority of Members, will likely give the same therapeutic outcomes for a health problem.

Closed Panel Plan — a health maintenance organization (HMO), preferred provider organization (PPO) or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly, indirectly, or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel provider.

COBRA - stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law allows people to continue their insurance for a period of time after ending a job or due to a qualifying event.

Coinsurance - percentage of costs you share with Us.

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.

Coordination of Benefits - it is where an insurance policy prevents duplicate payments for services covered by more than one insurance policy. For example, you may be covered by your own policy, as well as a spouse's policy. Medical costs are covered first by the person's own policy. Any balance is submitted to the spouse's insurance policy for additional review or payment.

Copayment - is a fixed amount you must pay out of your own pocket for service by a Provider.

Cosmetic - services to keep, change or improve your appearance or are done for mental reasons.

Cost Sharing - the term used for out-of-pocket costs you pay, for example Copayments and Coinsurance paid by you.

Covered Services - services, supplies or treatments which are:

- Medically Necessary or included as a benefit under this Booklet;
- Within the scope of the Provider’s license;
- Given while covered under this Booklet is in force;
- Not Experimental or Investigational or not covered by this Booklet; and
- Allowed ahead of time by Us where Preauthorization is required by this Booklet.

Creditable Coverage - health coverage that you had within 90 days before coverage with Us under this Booklet. A creditable health coverage includes Medicare or Medicaid coverage, a group or individual health coverage, state high risk pool coverage, any federal or state health coverage or any other health coverage that gives basic medical and Hospital care.

Custodial Care - care primarily for your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, giving medicine which you usually do yourself or any other care for which the services of a Provider are not needed.

Dependent - a Subscriber’s legal spouse, common-law spouse, designated beneficiary, partner to a civil union, or child as defined in the “Eligibility” section of this Booklet.

Durable Medical Equipment - any equipment that can withstand heavy use to serve a medical need, is useless to a person who is not sick or hurt, and is appropriate for use at home.

Early Intervention Services - Services, as defined by Colorado law in accordance with Part C, that are authorized through an Eligible Child's IFSP but that exclude: nonemergency medical transportation; respite care; service coordination, as defined in federal law; and assistive technology (unless covered under this Booklet as durable medical equipment).

- Eligible Child - means an infant or toddler, from birth through two years of age, who is an eligible Dependent and who, as defined by Colorado law, has significant delays in development or has a diagnosed physical or mental

condition that has a high probability of resulting in significant delays in development or who is eligible for services pursuant to Colorado law.

- Individualized family service plan or IFSP - means a written plan developed pursuant to federal law that authorizes early intervention services to an Eligible Child and the child's family. An IFSP shall serve as the individualized plan for an Eligible Child from birth through two years of age.

Effective Date - the date coverage under this Booklet begins.

Emergency - the sudden, and at the time, unexpected onset of a health condition that a prudent person, having average knowledge of health services and medicine and acting reasonably would believe 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 your health in serious jeopardy.

Employer Master Contract - the agreement between Us and your employer stating all of the terms that applies to group coverage. The final interpretation of any terms found in this Booklet is governed by the Employer Master Contract.

Experimental or 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 (except as noted in the Clinical Trials section under Covered Services in this Booklet as required by state law), 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; or
- 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; or
- 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; or
- 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 - a form sent by Us to you after you have filed a claim. It includes items such as the date of service, name of Provider, amount covered and patient balance.

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

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

Health Benefit ID Card - the card We give you with information such your name and ID number for this plan.

HMO Colorado - a health maintenance organization, organized under the laws of the State of Colorado, doing business as HMO Colorado, Inc. Referred to in this Booklet as “Us”, “We”, or “Our.” Also referred to as "HMOC".

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 licensed or certified 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 Delivery Pharmacy - a service where you get Prescription Drugs (other than Specialty Pharmacy Drugs) through a mail order service.

Home Health Services - services provided by a Home Health Agency at your home. It includes skilled nursing services, certified and licensed nurse aide services, medical supplies, equipment, and appliances suitable for use in your home, and physical, occupational or speech therapy services, and social work practice services provided by a licensed social worker.

Hospice - a Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient’s Doctor. It must be licensed by the appropriate agency.

Hospital - a Facility Provider which offers beds and Covered Services 24 hours a day. It must be licensed by local and state regulatory agencies.

In-Network - a term describing Providers that enter into a network contract with Us for this specific health benefit plan.

Inpatient Rehab Therapy - care received while a Member is admitted as inpatient at a rehabilitation facility for the **primary purpose** of receiving rehabilitation services. Care includes a minimum of three hours of therapy, e.g., speech therapy, respiratory therapy, occupational therapy and/or physical therapy. Inpatient Rehab Therapy may be received from an acute rehabilitation facility, skilled nursing facility, long term acute care facility or sub-acute facility. Inpatient Rehab Therapy includes acute rehabilitation therapy, chronic rehabilitation therapy or sub-acute rehabilitation therapy.

Intractable Pain - a pain state in which the cause of the pain cannot be removed and which in the course of medical practice no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts. It includes evaluation by the attending Doctor and one or more Doctors specializing in the treatment of the part of the body thought of as the source of the pain.

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

Maximum Allowed Amount - The maximum amount that We will allow for Covered Services that you receive. More details can be found in the "How to Access Your Services and Obtain Approval of Benefits" section of this Booklet.

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.

Medically Necessary - the diagnosis, evaluation and treatment of a condition, illness, disease or injury that We solely decide to be:

- Medically appropriate for and consistent with your symptoms and proper diagnosis or treatment of your condition, illness, disease or injury;
- Obtained from a Doctor or Provider;
- Provided in line with medical or professional standards;
- Known to be effective, as proven by scientific evidence, in improving health;
- The most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted. It will need to be consistent with recognized professional standards of care. In the case of a Hospital stay, 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 always mean lowest cost. It does mean that as to the diagnosis or treatment of your illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- Not Experimental or Investigational;
- Not primarily for you, your families, or your Provider's convenience; and
- Not otherwise an exclusion under this Booklet.

The fact that a Doctor 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.

Medical Policy and Technology Assessment - a process We use to review and evaluate new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the experimental / investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 doctors from various medical specialties including Our medical directors, doctors in academic medicine and doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to medical necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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 Booklet. Also referred to in this Booklet as "you" or "your".

Mental Health and Substance Abuse - a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition. Coverage is also provided for Biologically Based Mental Illness for schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. It does not include Autism Spectrum Disorder, which under state law is considered a medical condition.

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.

Out-of-Network - a term for Providers that do not enter into a network contract with Us. Services received from an Out-of-Network Provider are only covered under limited circumstances.

Out-of-Pocket Annual Maximum - the Cost Sharing total that you may be responsible for under this Booklet for most medical and prescription costs. Benefit Period maximums or lifetime maximums under this Booklet will still apply, even if you have satisfied your Out-of-Pocket Annual Maximum.

Pharmacy and Therapeutics (P&T) Process - a process in which health care professionals including nurses, pharmacists, and physicians determine the clinical appropriateness of drugs and promote access to quality medications. The process also reviews drugs to determine the most cost effective use of benefits and advise on programs to help improve care. Our programs may include, but are not limited to, drug utilization programs, preauthorization criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives.

Preauthorization - a process during which requests for services or Prescription Drugs 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 Drug -

Brand Name Drug - the first version of a drug developed by a drug manufacturer. It can also be a version marketed under the manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent to manufacture and market a new drug for a certain number of years. After the patent expires and FDA rules are met, any manufacturer may produce and sell the drug under its own brand or under the drug's chemical or generic name.]

Drug List - a list of drugs developed in consultation with Doctors and pharmacists and approved for their quality and cost-effectiveness.

Generic Drug - a drug that is approved by the FDA as having the same active ingredient(s) as the Brand Name Drug. Normally, it is available only after the patent expires on a Brand Name Drug. On average, Generic Drugs cost less than Brand Name Drugs.

Legend Drug - a medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to show in the label, “Caution: Federal law prohibits dispensing without a prescription.” Compounded (combination) drugs, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer are considered prescription Legend Drugs. Insulin is considered a Legend Drug under this Booklet.

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

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

Prescription Drug Maximum Allowed Amount - is the maximum amount We allow for any Prescription Drug. The amount is determined by Us using Prescription Drug costs information given to Us by the Pharmacy Benefits Manager.

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

Doctor - A doctor of medicine or osteopathy who is licensed to practice medicine under the laws of the state or jurisdiction where care is given.

Professional Provider - a Doctor or other professional Provider who is licensed by the state or jurisdiction where Covered Services are provided for benefits to be payable. Such services are subject to review by a medical authority appointed by Us.

Facility Provider - examples of inpatient and outpatient facility Provider, recognized by Us and licensed by the state or jurisdiction where services are provided as follows:

Inpatient Facility Provider

- Hospital;
- Alcoholism Treatment Center;
- Residential Treatment Center;
- Hospice Facility;
- Skilled Nursing Care Facility; and

- Alternative Care Facility.

Outpatient Facility Provider

- Dialysis center;
- Veteran's Administration or Department of Defense Hospital;
- Home Health Agency;
- Alternative Care Facility; and
- Ambulatory surgery.

Mid-Level Provider - are registered nurses, clinical nurse specialists, nurse practitioners, physicians assistants or as determined by Us. Mid-Level Providers may not be selected as a PCP. We may assign the PCP Copayment to Covered Services of a Mid-Level Provider.

Primary Care Provider (PCP - is typically an internal medicine Doctor, family practice Doctor, general practitioner, pediatrician, advanced nurse practitioner, or advanced registered nurse practitioner who has contracted with Us to supervise, coordinate and provide initial and basic care.

Specialist - a professional, usually a Doctor, who is an expert on a specific disease, condition or body part.
Examples include:

- Psychiatrist;
- Orthopedist;
- Obstetrician;
- Gynecologist; and
- Cardiologist

Retail Health Clinic Provider - a facility that gives you limited basic medical care on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically given by Doctor assistants and nurse practitioners.

Qualified Early Intervention Service Provider - means a person or agency, as defined by Colorado law in accordance with Part C, who provides Early Intervention Services and is listed on the registry of early intervention service Providers.

Reconstructive Surgery - includes procedures that are meant to address a major change from normal in relation to accidental injury, disease, trauma, treatment of a disease or Congenital Defect.

Recorded Designated Beneficiary Agreement - an agreement entered into by two people for the purpose of making each a beneficiary of the other and which has been recorded with the county clerk and recorder in the county in which one of the person lives. The agreement is based on the Colorado Designated Beneficiary Act.

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, personal injury protection, or any other insurance coverage, to compensate the Member as a result of bodily 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 Reimbursement under the "General Policy Provisions" section of this Booklet.

Residential Treatment Center - is an inpatient treatment facility where the patient resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a mental or nervous disorder or substance abuse. The facility must be licensed to provide psychiatric treatment of mental or nervous disorders or rehabilitative treatment of substance abuse according to state and local laws.

Retail Pharmacy - a place licensed to dispense Prescription Drugs through a licensed pharmacist due to a Doctor's order.

Service Area - the geographic area where We are licensed to conduct business.

Skilled Nursing Care Facility (SNF) - a place that provides you with skilled nursing care, for example 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.

Specialty Drug List - a list of Specialty Pharmacy Drugs as determined by Us which must be obtained from the In-Network Specialty Pharmacy PBM and which are billed under the pharmacy benefit.

Specialty Pharmacy - a pharmacy that is designated by Us, other than a Retail Pharmacy, Home Delivery Pharmacy, 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 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.

Stabilize - medical treatment you get in an Emergency as may be needed to make sure that material deterioration of your condition is not likely to result from or during:

- Your discharge from an emergency unit or other care setting where Emergency care is given to you;
- Your transfer from an emergency unit or other care setting to another facility; or
- Your transfer from a Hospital emergency unit or other Hospital care setting to the Hospital's inpatient setting.

Step Therapy - process that first requires the use of designated drug over others for treatment as supported by clinical practice guidelines.

Sub-Acute Rehab Therapy - care that includes a minimum of one hour of therapy when you can no longer tolerate, but it does not require three hours of therapy a day. This type of rehab is normally done in a Skilled Nursing Facility.

Subcontractor - We may subcontract particular services to organizations that are experts in certain areas. This may include services for Prescription Drugs, Mental Health and Substance Abuse. Such organizations may make decide on benefits or perform administrative, claims paying, or member services duties on Our behalf.

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

Substance Dependency - a condition which you use alcohol, drugs and other substances in a manner that damages your health or loses your ability to control your actions.

Surgery - any variety of technical procedures for treatment or diagnosis of anatomical disease or injury, such as 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 Anesthesia and pre- and post-operative care, including recasting.

Telemedicine - is used to support health care when you and the Doctor are physically separated. Typically, you communicate through an interactive mean that is enough to start a link to the Provider who is working at a different location from you.

Therapeutic Care - for purposes of the Autism Spectrum Disorders, this type of care is provided by a speech, occupational or physical therapist, or an Autism Services Provider. Therapeutic Care includes speech, occupational, and applied behavior analytic and physical therapies.

Transplant Benefit Period - the Transplant Benefit Period starts one day prior to a covered transplant procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network transplant Provider agreement.

Urgent Care - is not an Emergency, but an unexpected illness or injury requiring treatment that cannot reasonably be postponed for regularly scheduled care.

Urgent Care Center - an office or facility where care is provided for you in an Urgent Care situation.

Utilization Review - a set of formal techniques to monitor 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 reviewing whether or not a procedure or treatment is considered Experimental or

Investigational, and reviewing your medical circumstances when such a review is needed to determine if an exclusion applies.

End of Booklet