Funded by the University of Colorado Health and Welfare Trust

Health Plan
Extended



A guide to your benefits

2021-22

Benefit Booklet
Section 1. Federal Notices

The University of Colorado, as Plan Sponsor of the University of Colorado Health and Welfare Plan ("the University"), complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The University does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The University provides free aids and services to people with disabilities to communicate effectively, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). The University also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the HIPAA Privacy Officer with CU Health Plan Administration.

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

HIPAA Privacy Officer
CU Health Plan Administration
1800 Grant Street, Suite 620
Denver, CO 80203
(303) 860-4199
(303) 860-4177 (fax)
cuhealthplan@cu.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the HIPAA Privacy Officer with CU Health Plan Administration is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician / Provider

We generally allow the designation of a Primary Care Physician / Provider (PCP). You have the right to designate any PCP who participates in the Claim Administrator's network and who is available to accept you or your family members. For information on how to select a PCP, and for a list of PCPs, contact the Member Services telephone Member Services telephone number on the back of your Identification Card or refer to the Claim Administrator's website, www.anthem.com/cuhealthplan. For children, you may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need referral from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claim Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Precertification for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics

or gynecology, contact the Member Services telephone Member Services telephone number on the back of your Identification Card or refer to the Claim Administrator's website, www.anthem.com/cuhealthplan.

Additional Federal Notices

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

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

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

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

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call us at the Member Services telephone number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child (ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child (ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits. Medical Necessity criteria are available upon request.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program).

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Member Services telephone number on your Identification Card, or contact the Employer.

Section 2.



Section 3. Welcome

Thank you for selecting the CU Health Plan as your insurance provider. By choosing this plan, you're backed by a team dedicated to providing you with the best health coverage possible and helping you save money at a time when healthcare costs are rising. You're committed to your personal wellness, and so are we.

If you're reading this, you're probably looking for information on how your plan works. You have enrolled in a health benefit plan that, pursuant to the terms of this booklet, pays for many of your healthcare expenses, including most expenses for physician and outpatient care, emergency care and hospital inpatient care. This plan is self-funded by the University of Colorado Health and Welfare Trust. That means all of the claims you make will be paid by the Trust, which is funded by contributions from you and other subscribers at the University of Colorado and CU Medicine. Anthem BlueCross and Blue Shield/HMO Colorado (Anthem) provides administrative services for your medical benefits, including provider network contracting, member services, care management, and other administrative services. Your prescription drug benefits are administered by CVS Caremark.

This booklet is a guide to your plan. Please review this document, as well as the summary of benefits on the Be Colorado website, to become familiar with your benefits, including their limitations and exclusions. Bookmark this document for quick reference when you need it. By learning how your coverage works, you'll be able to make the best healthcare decisions possible and take advantage of all the great benefits available to you.

For questions about medical coverage or how medical benefits are administered, please visit BeColorado.org or call Anthem's Member Services department. Anthem's toll-free Member Services department number is located on your Anthem Health Benefit ID Card. For questions about prescription coverage or how prescription benefits are administered please visit www.caremark.com or call the Member Services telephone number on the back of your CVS/Caremark ID card. Thank you for selecting the CU Health Plan for your healthcare needs. We wish you good health.



Tony DeCrosta
Chief Plan Administrator
University of Colorado Health and Welfare Trust

Member Rights and Responsibilities

As a Member you have rights and responsibilities when receiving health care. As your health care partner, we want to make sure your rights are respected while providing your health benefits. That means giving you access to our network health care Providers and the information you need to make the best decisions for your health. As a Member, you should also take an active role in your care.

You have the right to:

- Speak freely and privately with your health care Providers about all health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your Plan.
- Work with your Doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private by following our privacy policies, and state and Federal laws.
- 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 health care Providers.
  - Your rights and responsibilities.
  - The rules of your health Plan.
  - The way your health Plan works.
- Make a complaint or file an appeal about:
  - Your health Plan and any care you receive.
  - Any Covered Service or benefit decision that your health Plan makes.
- Say no to care, for any condition, sickness or disease, without having an effect on any care you may get in the future. This includes asking your Doctor to tell you how that may affect your health now and in the future.
- Get the most up-to-date information from a health care Provider about the cause of your illness, your treatment and what may result from it. You can ask for help if you do not understand this information.

You have the responsibility to:

- Read all information about your health benefits and ask for help if you have questions.
- Follow all health Plan rules and policies.
- Choose an In-Network Primary Care Physician / Provider, also called a PCP, if your health Plan requires it.
- Treat all Doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call your health care Provider’s office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your health care Providers to make a treatment plan that you all agree on.
- Inform your 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 your care plan.
- Follow the health care plan that you have agreed on with your health care Providers.

- Give us, your Doctors and other health care Providers the information needed to help you get the best possible care and all the benefits you are eligible for under your health Plan. This may include information about other health insurance benefits you have along with your participation in this Plan.
- Inform Member Services if you have any changes to your name, address or family members covered under your Plan.

If you would like more information, have comments, or would like to contact us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

We want to provide high quality benefits and Member Services to our Members. Benefits and coverage for services given under the Plan 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 Services.

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Section 5. Eligibility

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

Eligibility is defined by the employer as defined in Appendix II of the University of Colorado Health and Welfare Plan, found at www.becolorado.org/trust. The employee must contact the Employer for the minimum number of hours that must be worked per week and other requirements to qualify for benefits.

Dependents

A Subscriber's Dependents may include the following:

- **Spouse/Partner.** As defined by your employer.
- **Newborn child**. A newborn child born to the Subscriber or Subscriber's Spouse is covered under the Subscriber's membership for the first 31 days after birth. If the mother of the newborn child is a Dependent child of the Subscriber, the newborn is **not** provided benefits (see the **Grandchild** heading in this section).

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

  To continue the newborn child's participation in the coverage beyond the 31-day period after the newborn child's birth, the Subscriber must complete and submit a Benefits Enrollment/Change Form or online submission to your employer or submit the change through the online enrollment tool (as available through your employer) to add the newborn child as a Dependent child to the Subscriber's policy. Your employer must receive the Benefits Enrollment/Change Form or online submission within 31 days after the birth of the child to continue coverage for the 32nd day and thereafter. For example: the newborn child is born on January 15th, you have 31 days from the birth to notify the employer of the newborn's birth. If the current coverage is a single only policy and the child is to continue coverage beyond 31 days, the effective date of coverage for the newborn child is on the date of birth and the change in the premium payment is effective on February 1st.

- **Adopted child**. An unmarried child (who has not reached 18 years of age) adopted while the Subscriber or the Subscriber's Spouse is eligible for benefits will be covered for 31 days after the date of placement for adoption.
  "Placement for adoption" means circumstances under which a Subscriber assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates when the legal obligation for support terminates.

  To continue the adopted child's participation in the Plan beyond the 31-day period after the adopted child's placement, the Subscriber must complete and submit a Benefits Enrollment/Change Form or online submission to your employer or submit the change through the online enrollment tool (as available through your employer) to add the adopted child as a Dependent child to the Subscriber's benefit Plan. The employer must receive the Benefits Enrollment/Change Form or online submission within 31 days after the placement of the child for adoption to continue coverage for the 32nd day and thereafter. For example: the placement of the adopted child is on January 15th, you have 31 days from the placement to notify the employer of the adoption. If the current coverage is a single only policy and the child is to continue coverage beyond 31 days, the effective date of coverage for the adopted child is on the date of placement and the change in the premium payment is effective on February 1st.

- **Dependent child**. A Subscriber's son, daughter, stepson, stepdaughter or eligible foster child, including a legally adopted individual or an individual who is lawfully placed with the Subscriber for legal adoption, or a child for whom the Subscriber has established parental responsibility (as evidenced by court documents), may be covered under the terms of this Booklet through the end of the calendar month in which the child turns 27. There may be tax consequences to the Subscriber when enrolling his or her child or a partner's child through the calendar month in which the child turns age 27. A Dependent child of a Subscriber who is no longer eligible for coverage may be eligible for continuation coverage. Information can be found under the heading **Continuation of Benefits** in this section of this Booklet.
- **Disabled Dependent child**. An unmarried child who is 27 years of age or older, continually enrolled, medically certified as disabled and dependent upon the parent may be covered under the terms of this Benefits Booklet. The employer must receive notice of the disability for the disabled Dependent coverage to continue after the Dependent child turns age 27.
- **Grandchild**. A grandchild of a Subscriber or a Subscriber's Spouse is not eligible for benefits unless the Subscriber or the Subscriber's Spouse is court-appointed as having parental responsibility for the grandchild or has adopted the grandchild. The Subscriber must submit a Benefits Enrollment/Change Form or online submission and evidence of court appointment as having parental responsibility or documents evidencing a legal adoption.

Medicare-Eligible Members

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

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

Enrollment Process

For eligible Subscribers and their eligible Dependents to participate in the Plan, the Subscriber must follow his/her employer's enrollment process, which details who is eligible and which applicable forms or online submission are required for enrollment. Eligibility for benefits under this Booklet begins as of the Effective Date as indicated in the employer's files. Services received before that date are not covered.

Note: Submission of a Benefits Enrollment/Change Form or online submission does not guarantee your enrollment.

You need to contact your employer for details regarding required documentation for adding Spouse/Partners and their dependents using the contacts below:

- University of Colorado – Employee Services
- University of Colorado Medicine – Human Resources

Initial Enrollment

Eligible employees may apply for benefits for themselves and their eligible Dependents by submitting a Benefits Enrollment/Change Form or online submission. The employer must receive the Benefits Enrollment/Change Form or online submission within 31 days after the date of hire or within 31 days of the expiration of the waiting period, as defined in the employer's new hire policy. The Effective Date of eligibility for benefits will be determined in accordance with any established waiting period as determined by the employer. The employer will inform the employee of the length of the waiting period.

If you terminate your benefits under this Plan, and within the same Benefit Year you enroll in another CU Health Plan benefit plan administered by Us, due to a special enrollment, all covered benefits that have a Benefit Period Maximum will be carried over to the new coverage. For example, if a benefit has a limit

of one visit per Benefit Period and you received that benefit under the prior plan, then you are not eligible under the new plan for the same benefit until the Benefit Period has expired, as benefits have been exhausted for your Benefit Period.

Open Enrollment
Any eligible employee may re-enroll each year during the employer's annual Open Enrollment period, which is generally 2- 3 weeks before the Plan's Anniversary Date. The Employer will provide the Open Enrollment period dates to eligible employees. The plan year begins on July 1.

Newly Eligible Dependent Enrollment
A current Subscriber of this coverage may add a Dependent who becomes newly eligible due to a qualifying event. Qualifying events include marriage, partnership, birth, and placement for adoption or issuance of a qualified medical child support court order. The employer must receive a Benefits Enrollment/Change Form or online submission for the addition of the Dependent within 31 days after the date of the qualifying event. Eligibility for benefits will be effective on the first of the month following the qualifying event.

When the Subscriber or the Subscriber's Spouse is required by a qualified medical child support order to provide medical benefits, the eligible Dependent must be enrolled within 31 days of the issuance of such order. The employer must receive a copy of the court or administrative order with the Benefits Enrollment/Change Form or online submission.

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.
- Lost coverage due to a reduction in the number of hours of employment.
- Lost coverage under a health benefit plan due to the divorce or legal separation of the covered employee's spouse.
- Lost eligibility under their states' medical assistance program.
- Experienced a termination of employment or eligibility for coverage, regardless of eligibility for COBRA or state continuation.
- Experienced an involuntary termination of coverage.
- The covered employee became ineligible for benefits under Title XVIII of the Federal Social Security Act, as amended.
- Has a reduction or elimination of group contributions toward the cost of the prior health plan.
- Had a parent or legal guardian disenroll a dependent, or a dependent becomes ineligible for the Children's Basic health Plan.
- 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.
- Became eligible (employee or dependent) for premium assistance under their states' medical assistance regulations.
- Entered into a Designated Beneficiary Agreement, or is required pursuant to a QMCSO or other court or administrative order mandating that the individual be covered.

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 state medical assistance program where the member resides, 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.

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.

Status Change 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 the eligible employee and/or eligible Dependents. The employee must properly file an application with the employer within 60 days after coverage has ended. In addition, 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, including any waiver or demonstration project conducted under or in relation to these plans. Similarly, the employee must properly file an application with the employer within 60 days after the eligibility date for assistance is determined.

Military Service

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances listed below. These rights apply only to employees and their Dependents covered under the Plan before the employee leaves for military service. Benefits under USERRA continuation of coverage shall end on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

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

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.

Section 6. How to Access Your Services and Obtain Approval of Benefits

Introduction

Your Plan is an EPO plan. **To get benefits for Covered Services, you must use In-Network Providers, unless we have approved an Authorized Service or if your care involves Emergency or Urgent Care.**

In-Network Services

When you get care from an In-Network Provider or as part of an Authorized Service, benefits are available for Covered Services. Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

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. For example, some Hospital-based labs are not part of our Reference Lab Network. Please read the "Member Payment Responsibility" section for additional information on Authorized Services.

Please see "Inter-Plan Arrangements, Out-of-Area Services" under the "Claims Procedure (How to File a Claim)" section for additional information.

Primary Care Physicians / Providers (PCP)

PCPs include general practitioners, internists, family practitioners, pediatricians, or other qualified Primary Care Providers, as required by law. Each Member should choose a PCP who is listed in the Provider directory. Each Member of a family may select a different Primary Care Physician. For example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If you want to change your PCP, call us or see our website, www.anthem.com/cuhealthplan.

The Primary Care Physician is the Doctor who normally gives, directs, and manages your health care.

If, when you first enroll (sign up) for coverage under this Plan, you are under the care of an Out-of-Network Provider, you should tell us right away. To keep getting care under this Plan from any Out-of-Network Provider, we must approve an Authorized Service with that Provider or the services will be denied.

Selecting a Primary Care Physician

Your Plan requires you to select a Primary Care Physician from our network, or we will assign one. We will notify you of the PCP that we have assigned. You may then use that PCP or choose another PCP from our Provider Directory. Please see "How to Find a Provider in the Network" for more details.

The First Thing To Do – Make an Appointment With Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history.
- Your family health history.
- Your lifestyle.
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are a CU Health Plan-Extended Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any In-Network Specialist including a behavioral health Provider. You do not have to get a Referral.

If you have any questions about Covered Services, call us at the telephone number listed on the back of your Identification Card.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of In-Network Providers at www.anthem.com/cuhealthplan, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Member Services to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Member Services before you get services for more information.

If you need details about a Provider's license or training, or help choosing a Doctor who is right for you, call the Member Services Member Services telephone number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Please note that we have several networks, and that a Provider that is In-Network for one plan may not be In-Network for another. Be sure to check your Identification Card or call Member Services to find out which network this Plan uses.

Continuity of Care

If your In-Network Provider leaves our network because we have terminated their contract without cause, and you are in active treatment, you may be able to continue seeing that Provider for a limited period of time and still get In-Network benefits. "Active treatment" includes:

1) An ongoing course of treatment for a life-threatening condition,
2) An ongoing course of treatment for a serious acute condition, (examples include chemotherapy, radiation therapy and post-operative visits),
3) The second or third trimester of pregnancy and through the postpartum period; or
4) An ongoing course of treatment for a health condition for which the Physician or health care Provider attests that discontinuing care by the current Physician or Provider would worsen your condition or interfere with anticipated outcomes.

An “ongoing course of treatment” includes treatments for mental health and substance use disorders.

In these cases, you may be able to continue seeing that Provider for up to 90 days. If treatment is not complete at the end of 90 days, you may, depending on the condition be entitled to a longer period as allowed by law. If you wish to continue seeing the same Provider, you or your Doctor should contact Member Services for details. Any decision by us regarding a request for Continuity of Care is subject to the appeals process.

Benefit Maximum

Some Covered Services have a maximum number of days, visits or dollar amounts that we will allow during a Benefit Period. When the Deductible (if applicable) is applied to a Covered Service which has a maximum number of days or visits, the Benefit Maximum may be reduced by the amount applied to the Deductible, whether or not the Covered Service is paid by us. Even after you satisfy the Out-of-Pocket Annual Maximum, our reimbursement remains limited by the Benefit Maximums of this plan.

If you leave this Plan, and go on to a new Plan with us in the same Benefit Period, Covered Services that have a Benefit Maximum will be carried over to the new Plan. For example, if a benefit has a limit of one visit per Benefit Period and you received that benefit under the prior coverage, then you are not eligible under the new Plan for the same benefit until the Benefit Period ends, as benefits have been exhausted for your Benefit Period.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard", which provides services to you when you are outside our Service Area. For more details on this program, please see “Inter-Plan Arrangements” in the “Claims Procedure (How to File a Claims)” section.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Fees for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

Reviewing Where Services Are Provided

A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different Provider or Facility may need to be used in order for the service to be considered Medically Necessary.

Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imaging center, infusion center, Ambulatory Surgical Facility, or in a Physician’s office.

- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a treatment that was asked for is not Medically Necessary if clinically equivalent treatment that is more cost effective is available and appropriate. “Clinically equivalent” means treatments that for most Members, will give you similar results for a disease or condition.

If you have any questions about the Utilization process, the medical policies, or clinical guidelines, you may call the Member Services phone Member Services telephone number on the back of your Identification Card.

However, coverage for or payment of the service or treatment reviewed is not guaranteed even if we decide your services are Medically Necessary. For benefits to be covered, we may consider on the date you get service:

1. You must be eligible for benefits;
2. Fees must be paid for the time period that services are given;
3. The service or supply must be the same as was precertified;
4. The service or supply must be for the same condition and setting that was precertified; and
5. You must not have exceeded any applicable limits under your Plan.

Types of Reviews

- **Pre-service Review –** A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
- **Precertification** – A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

  For emergency services, Precertification is not required. For admissions following Emergency Care, you, your authorized representative or Doctor must tell us within 72 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not needed unless the admission lasts beyond the first 48 hours for a vaginal delivery or 96 hours for a cesarean delivery, or if the baby is not sent home at the same time as the mother.
- **Continued Stay / Concurrent Review** - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-Service and Continued Stay / Concurrent Reviews may be considered on an urgent or expedited timeframe when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment, or if you have a physical or mental disability, would create an imminent and substantial limitation on your existing ability to live independently. Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a Precertification, or when a needed Precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Who is Responsible for Precertification?

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician / Provider and other In-Network Providers have been given

detailed information about these procedures and in Colorado are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor ("requesting Provider") will get in touch with us to ask for a Precertification. However, you may request a Precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances. To get more information on what services need Precertification, you or your representative may call Member Services.

Provider Network Status	Responsibility to Get Precertification	Comments
In Network	Provider	• The Colorado Provider must get Precertification when required
Out of Network/ Non-Participating	Member	You have no benefit coverage for an Out-of-Network Provider unless: • You get approval to use an Out-of-Network Provider before the service is given, or. • You require Emergency or Urgent Care (See note below.) If these are true, then • You must get Precertification when required. (Call Member Services.) For an Emergency or Urgent Care admission, Precertification is not required. However, you, your authorized representative, or Doctor must tell us within 72 hours of the admission or as soon as possible within a reasonable period of time. • You may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary, not Emergency or Urgent Care, or any charges in excess of the Maximum Allowed Amount.
BlueCard Provider	Member **(Except for Inpatient Admissions)**	• You must get Precertification when required. (Call Member Services.) • You may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary. • **BlueCard Providers must obtain Precertification for all Inpatient Admissions.**

Provider Network Status	Responsibility to Get Precertification	Comments
NOTE: For an Emergency or Urgent Care admission, Precertification is not required. However, you, your authorized representative or Doctor must tell us within 72 hours of the admission or as soon as possible within a reasonable period of time.		

How Decisions are Made

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. This includes decisions about Prescription Drugs as detailed in the section "Prescription Drugs Administered by a Medical Provider". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Precertification phone Member Services telephone number on the back of your Identification Card.

If you are not satisfied with our decision under this section of your benefits, please refer to the "Appeals and Complaints" section to see what rights may be available to you.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued other state-specific requirements may apply. You may call the phone Member Services telephone number on the back of your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision and Notification
Expedited Pre-service Review	72 hours from the receipt of request
Non-expedited Pre-service Review	15 calendar days from the receipt of the request
Expedited Continued Stay / Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
– Expedited Continued Stay / Concurrent Review when request is received more than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Non-expedited Continued Stay / Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make our decision, we will tell the requesting Provider of the specific information needed to finish the review. If we do not get the specific information we need by the required timeframe, we will make a decision based upon the information we have.

We will notify you and your Provider of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Important Information

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) and/or offer an alternate benefit if in our sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program or a Provider agreement 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 Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider agreement by checking your on-line Provider Directory, or contacting the Member Services Member Services telephone number on the back of your Identification 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 Plan's Members.

Health Plan Individual Case Management

Our health plan individual case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of you and Anthem and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

Acute Care at Home Programs

Anthem has programs available that offer acute care to Members where they live as an alternative to staying in a Facility, when the Member's condition and the Covered Services to be delivered, are appropriate for the home setting. We refer to these programs as Acute Care at Home Programs. These programs provide care for active, short-term treatment of a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. Acute care services are generally delivered by teams of health care Providers from a range of medical and surgical specialties. The Acute Care at Home Programs are separate from our Home Care Services benefit, are only available in certain service areas, and are only provided if the Member's home meets accessibility requirements.

Covered Services provided by Acute Care at Home Programs may include Physician services (either in-person or via telemedicine), diagnostic services, surgery, home care services, home infusion therapy, Prescription Drugs administered by a Provider, therapy services, and follow-up care in the community. Prescription Drugs at a Retail or Mail Order Pharmacy are not included in these Programs. Benefits for those Drugs are described under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section. Acute Care at Home Programs may also include services required to set up telemedicine technology for in-home patient monitoring, and may include coverage for meals.

Members who qualify for these programs will be contacted by our Provider, who will discuss how treatment will be structured, and what costs may be required for the services. Benefit limits that might otherwise apply to outpatient or home care services, (e.g., home care visits, physical therapy, etc.), may not apply to these programs.

Your participation in these programs is voluntary. If you choose to participate, your Provider will discuss the length of time that benefits are available under the program (e.g., the Acute Care at Home Benefit Period) when you enroll. The Acute Care at Home Benefit Period typically begins on the date your Acute Care at Home Provider sets up services in your home, and lasts until the date you are discharged from the Program.

Any Covered Services received before or after the Acute Care at Home Benefit Period will be covered according to the other benefits of this Plan.

Section 7. Benefits/Coverage (What is Covered)

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Be sure to read "How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)" for more information on your Plan's rules. Read the "Limitations/Exclusions (What is Not Covered)" section for important details on Excluded Services.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if you have surgery, benefits for your Hospital stay will be described under "Inpatient Hospital Care" and benefits for your Doctor's services will be described under "Inpatient Professional Services". As a result, you should read all sections that might apply to your claims.

You should also know that many of Covered Services can be received in several settings, including a Doctor's office, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where you choose to get Covered Services, and this can result in a change in the amount you need to pay.

Please note that care must be received from your Primary Care Physician (PCP) or another In-Network Provider to be a Covered Service under this Plan. If you use an Out-of-Network Provider, your entire claim will be denied unless:

- **The services are for Emergency or Urgent Care; or**
- **The services are approved in advance by Anthem as an Authorized Service.**

Acupuncture/Nerve Pathway Therapy

Please see "Therapy Services" later in this section.

Allergy Services

Your Plan includes benefits for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Services

Medically Necessary ambulance services are a Covered Service when:

- 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.

And one or more of the following are met:

- 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.
- For air or water ambulance, you are taken:
  - From 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 an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require Precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. For Emergency ambulance services performed 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. If you do not use the air ambulance Provider we select, no benefits will be available. 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.

Ambulance services are not covered 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 are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A Doctor's office or clinic;
- A morgue or funeral home.

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, the Plan 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 a rehabilitation facility), or if you are taken to a Physician'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 Physician.**

Autism Services

Covered Services are provided for the assessment, diagnosis, and treatment of Autism Spectrum Disorders (ASD). 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;
- 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.

Autism services and the Autism Treatment Plan are subject to review under the "How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)" section.

Behavioral Health Services

See "Mental Health and Substance Abuse Services" later in this section.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Chiropractic Care

Please see "Therapy Services" later in this section.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to you as a participant in an approved clinical trial if the services are Covered Services under this Plan. 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:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. 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.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. 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 of Health and Human Services 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.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

All requests for clinical trials services, including services that are not part of approved clinical trials, will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service; or

ii. 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

iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

Benefits are also available for dental work needed to treat injuries to the jaw, sound natural teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition.

Treatment must begin within 12 months of the injury or as soon after that as possible to be a Covered Service under this Plan.

Cleft Palate and Cleft Lip Conditions

Benefits are available 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

- Prosthodontic and surgical reconstruction for the treatment of cleft palate and/or cleft lip

If you have a dental plan, the dental plan would be the main plan and must fully cover orthodontics and dental care for cleft palate and cleft lip conditions.

Dental Anesthesia for Children

Benefits are available 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; or
- Has dental needs for which local anesthesia is not effective because of acute infection, anatomic variation or allergy; or
- 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.

Other

The only other Covered Services are Facility charges for inpatient and/or outpatient care but do not include charges for the dental services. Benefits are payable in such settings are Medically Necessary for the Member's health problem or the dental treatment calls for it to keep you safe.

Diabetes Equipment, Education, and Supplies

Your Plan covers 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 Provider who is certified, registered or with training in diabetes. Diabetes training sessions must be provided by a Provider in an outpatient Facility or in a Doctor's office.

Screenings for gestational diabetes are covered under "Preventive Care" later in this section.

Diagnostic Services

Your Plan includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Provider and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.
- Genetic tests, when allowed by us.

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

See “Therapy Services” later in this section.

Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.
- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include repair and replacement costs as well as supplies and equipment needed for the use of the equipment or device, for example, a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services.

Orthotics

Benefits are available for certain types of orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support,

align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Custom foot orthotics, orthopedic shoes or footwear or support items are also covered.

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are required to adequately meet your needs.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

1) Artificial limbs and accessories. For prosthetic arms and legs we cover up to the benefits amounts provide by federal laws for Medicare or where needed to meet applicable health insurance laws;
2) One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes, or when needed to replace human lenses absent at birth, or due to ocular injury, or for the treatment of keratoconus or aphakia;
3) Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act;
4) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care;
5) Restoration prosthesis (composite facial prosthesis);
6) The first wig needed after cancer treatment;
7) Cochlear implants;
8) Your Plan covers 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 the prior "Diagnostic Services" of this section;
    - Hearing aids (monaural or binaural) including ear mold(s), bone-anchored hearing aids, the hearing aid instrument, batteries, cords and other ancillary equipment. The Plan covers auditory training when it is offered using approved professional standards. A new hearing aid will 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 aids.

Medical and Surgical Supplies

Your Plan includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, diabetic supplies, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products unless they are received from a community source, such as blood donated through a blood bank.

Emergency Care Services

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Emergency Services

Services provided for conditions that do not meet the definition of Emergency will not be covered.

Emergency (Emergency Medical Condition)

"Emergency," or "Emergency Medical Condition" means a medical or behavioral health condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient's health or the health of another person in serious danger or, for a pregnant woman, placing the woman's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by us.

Emergency Care

"Emergency Care" means a medical or behavioral health exam within the capability of the Emergency Department of a Hospital, and includes ancillary services routinely available in the Emergency Department to evaluate an Emergency Medical Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

With respect to an Emergency, stabilize means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the Member from a Facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to effect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service, and you will not need to pay more than what you would have if you had seen an In-Network Provider.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as possible. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)" for more details. If you or your Doctor do not call us, you may have to pay for services that are determined to be not Medically Necessary.

Treatment you get after your condition has stabilized is not Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will not be availableunless we agree to cover them as an Authorized Service.

Habilitative Services

Benefits also include habilitative health care services and devices that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Please see "Therapy Services" later in this section for further details.

Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in your home. Home care is covered only when such care is necessary as an alternative to Hospital stay. To be eligible for benefits, you must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Prior Hospital stay

is not required. Home care must be prescribed by a Doctor, under a plan of care established by the Doctor in collaboration with a Home Health Care Agency. We must preauthorize all care and reserve the right to review treatment plans at periodic intervals.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Provider as approved by us.
- Therapy Services of physical, occupational, speech and language, respiratory and inhalation (except for Chiropractic Care / Manipulative Therapy which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment, prosthetics and orthopedic appliances
- Private duty nursing services in the home

When available in your area, benefits are also available for Intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are described in the “Mental Health and Substance Abuse Services” section below.

Home Infusion Therapy

See “Therapy Services” later in this section.

Hospice Care

You are eligible for hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

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 and 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 for one year after the Member's death.
- Transportation.

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 services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan. 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 (Bone Marrow / Stem Cell) Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants. Certain transplants (e.g., cornea and kidney) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

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 the Blue Cross and Blue Shield Association. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of 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.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Excellence by us or has not been selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Transplant Benefit Period

At an In-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before 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.

Prior Approval and Precertification

To best understand your benefits, you may call our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. We suggest you do this before you have an evaluation and/or work-up for a transplant, so that we can assist you in maximizing your benefits. To learn more or to find out which Hospitals are In-Network Transplant Providers, you may contact the Member Services Member Services telephone Member Services telephone number on the back of your Identification Card and ask for the transplant coordinator. In addition, you or your Provider must call our Transplant Department for Precertification prior to the transplant, whether this is performed in an Inpatient or Outpatient setting.

Precertification 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 send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection 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 tests. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or collection 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 complete information.

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

Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care,
- Mileage within the medical transplant Facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Phone calls,

- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation,
- Meals.

Infertility Services

Please see “Maternity and Reproductive Health Services” later in this section.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital’s average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother’s normal Hospital stay.
- Newborn care for during and after the mother’s maternity Hospital stay for treatment of injury and sickness and medically diagnosed Congenital Defects and Birth Abnormalities.
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- Treatment for a health problem by a Doctor who is not your surgeon while you are in the Hospital for surgery. Benefits include treatment by two or more Doctors during one Hospital stay when the nature or severity of your health problem calls for the skill of separate Doctors.

- A personal bedside exam by another Doctor when asked for by your Doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy, Complications of Pregnancy, and for services needed for a miscarriage. Covered maternity services include:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent;
- Prenatal, postnatal and postpartum services; and
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by us.

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). 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. However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, we may not require a Provider to get authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Contraceptive Benefits

Benefits include oral contraceptive Drugs, injectable contraceptive Drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details. At least one product in all 18 approved methods of contraception is covered under this policy without cost sharing as required by federal and state law.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

Abortion Services

Benefits include services for a therapeutic abortion, which is an abortion recommended by a Doctor, performed to save the life or health of the mother, or as a result of incest or rape.

Infertility Diagnostic Services

Although this Plan offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits do not include assisted reproductive technologies (ART) or the diagnostic tests and Drugs to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. As part of other Covered Services under this Plan, benefits may also include services to treat the underlying medical conditions that may be associated with involuntary infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Fertility treatments such as artificial insemination and in-vitro fertilization are not a Covered Service.

Medical Foods

Covered Services include Medically Necessary 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 the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions. Disorders include those as required by law, including but not limited to:

- 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 acidemias;
- Propionic acidemia;
- Immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins;
- Severe food protein induced enterocolitis syndrome;
- Eosinophlic disorders as evidenced by the results of a biopsy; and
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.

Covered Services 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 a Pharmacy and are subject to the pharmacy payment requirements. Please see “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” later in this section.

Mental Health and Substance Abuse Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
  - Observation and assessment by a physician weekly or more often,
  - Rehabilitation and therapy.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs and (when available in your area) Intensive In-Home Behavioral Health Services.
- **Online Visits** when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice or other platform approved by us. Online visits generally do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, Plan coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit Precertification, or Doctor to Doctor discussions. Online visits are not the same as Telehealth Services and can, at times, include audio-only interactions but generally do not include store-and-forward transfers.

Examples of Providers from whom you can receive Covered Services include:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any Provider licensed by the state to give these services, when we have to cover them by law.

Occupational Therapy

Please see “Therapy Services” later in this section.

Office Visits and Doctor Services

Covered Services include:

Office Visits for medical care (including second surgical opinions) to examine, diagnose, and treat an illness or injury.

Consultations between your Primary Care Physician and a Specialist, when approved by Anthem.

Home Visits for medical care to examine, diagnose, and treat an illness or injury. Please note that Doctor visits in the home are different than the “Home Care Services” benefit described earlier in this Booklet.

Retail Health Clinic Care for limited basic health care services to Members on a “walk-in” basis. These clinics are normally found in major pharmacies or retail stores. Health care services are typically given by Physician’s Assistants or Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

Walk-In Doctor’s Office for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in Doctor’s office.

Urgent Care as described in “Urgent Care Services” later in this section.

Online Visits when available in your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice or other platform approved by us. Online visits generally do not

include reporting normal lab or other test results, requesting office visits, getting answers to billing, Plan coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit Precertification, or Doctor to Doctor discussions. Online visits are not the same as Telehealth Services and can, at times, include audio-only interactions but generally do not include store-and-forward transfers. For Mental Health and Substance Abuse Online Visits, see the "Mental Health and Substance Abuse Services" section.

Prescription Drugs Administered in the Office

Orthotics

See "Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies" earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgical Facility,
- Mental Health / Substance Abuse Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services,
- Therapy services.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under the "Diagnostic Services" benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services.

Covered Services fall under the following broad groups:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
    a. Breast cancer,
    b. Cervical cancer,
    c. Colorectal cancer,
    d. High blood pressure,

e. Type 2 Diabetes Mellitus,

f. Cholesterol,

g. Child and adult obesity.

Tobacco use screening and tobacco cessation counseling and intervention is also covered.

2) Immunizations for children, adolescents, and adults, including cervical cancer vaccinations for females, where recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3) Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;

4) Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

   a. Women's contraceptives, sterilization treatments, and counseling. This includes Generic oral contraceptives as well as injectable contraceptives and patches, for the durations or supply minimums required by applicable law. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. At least one product in all 18 approved methods of contraception is covered under this policy without cost sharing as required by federal and state law. Brand Drugs will be covered as a Preventive Care benefit when Medically Necessary, according to your attending Provider, otherwise they will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."

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

   c. Gestational diabetes screening.

5) Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:

   a. Counseling

   b. Prescription Drugs obtained at a Retail or Home Delivery (Mail Order) Pharmacy

   c. Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

6) Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

   a. Aspirin

   b. Folic acid supplement

   c. Bowel preparations

   Please note that certain age and gender and quantity limitations apply.

You may call Member Services at the number on your Identification Card for more details about these services or view the federal government's web sites: https://www.healthcare.gov/what-are-my-preventive-care-benefits, http://www.ahrq.gov, and http://www.cdc.gov/vaccines/acip/index.html.

In addition to federal and state law rules, Covered Services also include:

1) Annual medical diabetes eye exams, or in accordance with the frequency determined by your Provider.

2) Flu shot from a flu shot clinic. Coverage is provided for one flu shot per Benefit Period, or more often as we decide. To learn more about flu shot clinics, how much we reimburse you for a flu shot, and to get the claim form, visit our website at www.anthem.com/cuhealthplan. You may also call 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.

Prosthetics

See “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.

Please see “Therapy Services” in this section for further details.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent, rehabilitative or habilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility, or is otherwise licensed to provide the services. Custodial Care is not a Covered Service.

Smoking Cessation

Please see the “Preventive Care” section in this Booklet.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

Your Plan covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary;

- Medically Necessary pre-operative and post-operative care.

Bariatric / Weight Loss Surgery

Services and supplies will be covered in connection with Medically Necessary surgery for weight loss; but only for morbid obesity and only when surgery satisfies Anthem's medical policy. You or your Physician must obtain Precertification for all bariatric surgical procedures.

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered, except as listed in this Booklet.

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral / surgical correction of accidental injuries as indicated in the "Dental Services" section.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: This section does not apply to orthognathic surgery. See the "Oral Surgery" section above for that benefit.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, 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 symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

When due to breast cancer, reconstructive and surgical coverage will be provided in a manner determined in consultation with the attending Physician and the Member. Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

Telehealth Services

Covered Services that are appropriately provided by a telehealth Provider in accordance with applicable legal requirements will be eligible for benefits under this Booklet. Telehealth means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health. In-person contact between a health care Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. Telehealth is two-way audio-visual communication, including synchronous interactions and store-and-forward transfers.

Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail. If you have any questions about this coverage, or receive a bill please contact Member Service at the Member Services telephone number on the back of your Identification Card.

Therapy Services

Physical Medicine Therapy Services

For children under age 6, your Plan covers at least 20 visits, each, of physical, speech and occupational therapy. Benefits include the treatment of Congenital Defects and Birth Abnormalities, even if it is 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.

For age 6 and older, your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time.

Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices. It does not include massage therapy services.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct a speech impairment. 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.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic Care /Osteopathic / Manipulative therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but Chiropractic Care / Manipulative Therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments. Chiropractic benefits are Covered Services limited to office visits for evaluation, manual manipulation of the spine, laboratory services, X-ray of the spine and certain physical modalities and procedures for musculoskeletal disorders.
- **Acupuncture/Nerve Pathway therapy** – Treatment of neuromusculoskeletal pain by a Provider who acts within the scope of their license. Treatment involves using needles along specific nerve pathways to ease pain.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for you after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.

- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transgender Services

This Plan provides benefits for many of the charges for transgender surgery (also known as sex reassignment surgery) as part of the treatment of gender dysphoria or gender identity disorder. Benefits must be approved by us for the type of transgender surgery requested and must be authorized prior to being performed.

Charges 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.

Transplant Services

See "Human Organ and Tissue Transplant" earlier in this section.

Urgent Care Services

Often an urgent rather than an Emergency health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office visit. Urgent health problems are not life threatening and do not call for the use of an Emergency Room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Care for broken bones;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider. Urgent Care you get from an Out-of-Network Provider will be covered as an In-Network service, you will not need to pay more than what you would have if you had seen an In-Network Provider.

Vision Services

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the “Preventive Care” benefit.

Benefits do not include glasses or contact lenses except as listed in the “Prosthetics” benefit under “Durable Medical Equipment and Medical Devices, Orthotics, Prosthetics, and Medical and Surgical Supplies.”.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs, that must be, administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting.

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 to give more details before we can decide if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used, where permitted by law, prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of an Anthem's Prescription Drug List (a formulary developed by Anthem) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Compound drugs are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Precertification

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. We will give the results of our decision to both you and your Provider.

For a list of Prescription Drugs that need Precertification, please call the phone Member Services telephone number on the back of your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Expedited Precertification – We will review Expedited requests for Precertification of Prescription Drugs according to the timeframes listed below:

- If all needed information is provided with the request, we will approve or deny it within one business day of receiving the request, unless a shorter period of time is required by law;
- If we need more information to make a decision, we will tell the prescribing Provider what information is needed within one business day of receiving the request. If the information is timely provided, we will make a decision within the timeframes provided by law;
- If the prescribing Provider does not supply the requested information within two business days of receiving our request, the Precertification request will be deemed denied.

Non-Expedited Precertification – We will review non-Expedited requests for Precertification of Prescription Drugs according to the timeframes listed below:

- If all needed information is provided with the request, we approve or deny it within two business days of receiving the request;
- If we need more information to make a decision, we will tell the prescribing Provider what information is needed within two business days of receiving the request. If the information is timely provided, we will make a decision within the timeframes provided by law;
- If the prescribing Provider does not supply the requested information within two business days of receiving our request, the request will be deemed denied.

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 give notice of our decision as required by state and federal law.

Please refer to the section "How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)" under "Getting Approval for Benefits" for more details.

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

Designated Pharmacy Provider

Anthem in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Members. An In-Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the In-Network Provider must have signed a Designated Pharmacy Provider Agreement with us. You or your Provider can contact Pharmacy Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to you or your Provider and administered in your Provider's office, you and your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with you and your Provider to obtain Precertification and to assist shipment to your Provider's office.

We reserve our right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to you. Anthem may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in our discretion, such change can help provide cost effective, value based and/or quality services.

If you are required to use a Designated Pharmacy Provider and you choose not to obtain your Prescription Drug from a Designated Pharmacy Provider, you will not have coverage for that Prescription Drug.

You can get the list of the Prescription Drugs covered under this section by calling Pharmacy Member Services at the phone Member Services telephone number on the back of your Identification Card or check our website at www.anthem.com/cuhealthplan.

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 Doctor to make you aware of these choices. Only you

and your Doctor can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Pharmacy Member Services at the phone Member Services telephone number on the back of your Identification Card.

Section 8. Limitations/Exclusions (What is Not Covered)

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

1) **Acts of War, Disasters, or Nuclear Accidents** In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

   Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

2) **Administrative Charges**

   a) Charges to complete claim forms,

   b) Charges to get medical records or reports,

   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

3) **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.

4) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine, regardless of the Provider rendering such services or supplies. This includes, but is not limited to:

   a. Holistic medicine,

   b. Acupressure to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body, except as specifically listed as a Covered Service in this Plan,

   c. Homeopathic medicine,

   d. Hypnosis,

   e. Aroma therapy,

   f. Reiki therapy,

   g. Herbal, vitamin or dietary products or therapies,

   h. Naturopathy,

   i. Thermography,

   j. Orthomolecular therapy,

   k. Contact reflex analysis,

   l. Bioenergial synchronization technique (BEST),

   m. Iridology-study of the iris,

   n. Auditory integration therapy (AIT),

   o. Colonic irrigation,

   p. Magnetic innervation therapy,

   q. Electromagnetic therapy,

r. Neurofeedback / Biofeedback.

5) **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis and intensive behavior interventions) for all indications except as described under Autism Services in the "Benefits/Coverage (What is Covered)" section.

6) **Autopsies** Autopsies and post-mortem testing.

7) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

8) **Breast Reduction Surgery** (reduction mammoplasty) or services related to it, except as required by law or as medically necessary based on Anthem's medical policy.

9) **Certain Providers** Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet.

10) **Charges Not Supported by Medical Records** Charges for services not described in your medical records.

11) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services, except as written in this Plan. However, for Covered Emergency Care you receive from an Out-of-Network Provider at a facility in Colorado, the Out-of-Network Provider may be limited in their ability to collect these charges from you.

12) **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

13) **Clinically-Equivalent Alternatives** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the Member Services telephone number on the back of your Identification Card, or visit our website at www.anthem.com/cuhealthplan.

14) **Complications of/or Services Related to Non-Covered Services** Services, supplies or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

15) **Compound Drugs** Compound Drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations,* require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

16) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change**,** or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

17) **Court Ordered Testing** Court ordered testing or care unless the testing or care is Medically Necessary and otherwise a Covered Service under this Booklet.

18) **Crime** Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.

19) **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing. This Exclusion does not apply to services we authorize due to medical necessity or specific medical conditions.

20) **Custodial Care** Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

21) **Dental Devices for Snoring** Oral appliances for snoring.

22) **Dental Treatment** Excluded treatment includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances and all associated costs; and diagnosis and treatment for the teeth, jaw or gums such as:

- Removing, restoring, or replacing teeth;
- Medical care or surgery for dental problems (unless listed as a Covered Service in this Booklet);
- Services to help dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded, unless the chewing or biting results from a medical or mental condition.

This Exclusion does not apply to services that we must cover by law.

29) **Drugs Contrary to Approved Medical and Professional Standards** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

30) **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.

31) **Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations, and/or certifications, as determined by us.

32) **Drugs That Do Not Need a Prescription** Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.

33) **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes, except as listed in this Booklet. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

34) **Emergency Room Services for non-Emergency Care** Services provided in an emergency room for conditions that do not meet the definition of Emergency. This includes, but is not limited to, suture removal, routine pregnancy test, sore throat, ear ache/infection, rashes, sprains/strains, constipation, diarrhea, upper respiratory illness, abrasions, sleep disorder, conjunctivitis/pink eye, back pain that is not sudden and severe in onset, or dental caries/cavity in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.

35) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.

36) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

37) **Eye Exercises** Orthoptics and vision therapy.

38) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

39) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

40) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to care for flat feet, subluxations, cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

    a) Cleaning and soaking the feet.

    b) Applying skin creams to care for skin tone.

    c) Other services that are given when there is not an illness, injury or symptom involving the foot.

41) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

42) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

    If your Group is not required to have Workers Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part. This Exclusion also applies whether or not you claim the benefits or compensation, and whether or not you get payments from any third party.

43) **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

44) **Growth Hormone Treatment** Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

45) **Health Club Memberships and Fitness Services** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.

48) **Home Care**

    a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.

    b) Food, housing, homemaker services and home delivered meals.

49) **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

50) **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).

51) **Infertility Treatment** Infertility procedures. 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.

52) **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "Benefits/Coverage (What is Covered)" section.

53) **Massage Therapy** For massage therapy and manipulative techniques or procedures.

54) **Medical Equipment, Devices, and Supplies**

    a) Replacement or repair of purchased or rental equipment because of misuse, or loss/theft.

    b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

    c) Non-Medically Necessary enhancements to standard equipment and devices.

d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the “Benefits/Coverage (What is Covered)” section.

55) **Medicare** For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in “General Policy Provisions”. If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to www.Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

56) **Missed or Cancelled Appointments** Charges for missed or cancelled appointments.

57) **Non-approved Drugs** Drugs not approved by the FDA.

58) **Non-Approved Facility** Services from a Provider that does not meet the definition of Facility.

59) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines. Emergency medical care is not subject to this exclusion as long as such care meets the definition of Emergency medical care, see “Emergency Care” under the “Benefits/Coverage (What Is Covered)” section of this Booklet.

60) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

61) **Off label use** Off label use, unless we must cover it by law or if we approve it.

62) **Oral Surgery** Extraction of teeth, surgery for impacted teeth, and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

64) **Out-of-Network Care** Services from a Provider that is not in our network. This does not apply to Emergency Care, Urgent Care or Authorized Services.

65) **Pain** Intractable Pain and/or Chronic Pain.

66) **Personal Care, Convenience and Mobile/Wearable Devices**

a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, dehumidifiers, sports helmets, raised toilet seats, shower chairs, special lighting or other environmental modifiers, wristlets, augmentative communication devices, surgical supports, and corsets or other articles of clothing,

b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),

c) Home workout or therapy equipment, including treadmills and home gyms,

d) Pools, whirlpools, spas, or hydrotherapy equipment.

e) Hypo-allergenic pillows, mattresses, or waterbeds,

f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

67) **Private Duty Nursing** Private duty nursing services given in a Hospital or Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the "Home Care Services" benefit.

68) **Prosthetics** Prosthetics for sports or cosmetic purposes. This includes wigs, except as specifically stated in this Booklet, and scalp hair prosthetics.

69) **Residential accommodations** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center**.** This Exclusion includes procedures, equipment, services, supplies or charges for the following:

    a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

    b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

    c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

72) **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the "Preventive Care" benefit.

73) **Services received from a Provider outside of Colorado** Services received from a Provider outside of Colorado unless services are provided by a BlueCard Provider. This does not apply to:

    a) Emergency or Urgent Care; or

    b) Covered Services approved in advance by Anthem.

74) **Sexual Dysfunction** Services or supplies for male or female sexual problems.

75) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

76) **Sterilization** Services to reverse an elective sterilization.

77) **Studies** Research studies or screening exams, unless otherwise stated in this Booklet.

78) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

79) **Temporomandibular Joint Treatment (TMJ)** Services or supplies to treat temporomandibular and craniomandibular disorders, including, but not limited to fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

81) **Vein Treatment** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

82) **Vision Services** Vision services not described as Covered Services in this Booklet.

83) **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

84) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

85) **Wilderness or other outdoor camps and/or programs.**

Section 9. Member Payment Responsibility

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the "Definitions" section for a better understanding of each type of cost share.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by In-Network Providers is based on this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Inter-Plan Arrangement's" in the "Claims Procedure (How to File a Claim)" section for additional information.

The Maximum Allowed Amount for this Booklet 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 your Booklet and are not excluded;
- That are Medically Necessary; and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

Generally, services received from an Out-of-Network Provider under this product are not covered except for Emergency Care, Urgent Care, or when allowed as a result of a Referral by us.

When you receive Covered Services from a 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 received 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 occurs, 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 healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion

of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding an In-Network Provider or visit www.anthem.com/cuhealthplan.

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. If you use an Out-of-Network Provider, your entire claim will be denied except for Emergency or Urgent Care, or unless the services are approved by us as result of a Referral.

For Covered Services you receive from an Out-of-Network Provider for Emergency, Urgent Care or for services approved as a Referral, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our managed care fee schedules used with In-Network Providers, which we reserve the right to modify from time to time; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care; or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management;
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the six methods shown above unless the contract between us and that Provider specifies a different amount.

For Covered Services rendered outside Anthem's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price.

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to you. Please call Member Services for help in finding an In-Network Provider or visit our website at www.anthem.com/cuhealthplan.

Member Services is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your Out-of-Pocket responsibility. Although Member Services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your Plan design, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Also your cost share amount may vary depending on where the service is performed. For example, an outpatient service may have higher cost share if received from a Hospital, instead of a Doctor's office or freestanding Ambulatory Surgical Facility. We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances you may only be asked to pay the lower In-Network cost sharing amount when you use an Out-of-Network Provider. For example, you will pay the In-Network cost sharing levels and will not have to pay the difference between the Out-of-Network Provider's charges and the Maximum Allowable Amount:

1. if you get Covered Emergency Services at a Facility in Colorado; or
2. if you go to an In-Network Hospital or Provider Facility in Colorado and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist and you did not knowingly choose the Out-of-Network Provider.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available, or if we don't have an In-Network Provider within a reasonable number of miles from your home, for the Covered Service, we may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered Service. If approved, we will pay the Out-of-Network Provider at the In-Network level of benefits and you won't need to pay more for the services than if the services had been received from an In-Network Provider. A Precertification or preauthorization is not the same thing as an Authorized Service; we must specifically authorize the service from an Out-of-Network Provider at the In-Network cost share amounts.

Sometimes you may need to travel a reasonable distance to get care from an In-Network Provider. This does not apply if care is for an Emergency.

Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency 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.

Section 10. Claims Procedure (How to File a Claim)

This section describes how we reimburse claims and what information is needed when you submit a claim. When you receive care from an In-Network Provider, you do not need to file a claim because the In-Network Provider will do this for you.

Please remember that this Plan will not provide benefits for services from Out-of-Network Providers unless the claim is for Emergency and Urgent Care or for services approved in advance by Anthem as an Authorized Service.

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim in order for benefits to be paid.

- In-Network Providers will submit claims for you. They are responsible for ensuring that claims have the information we need to determine benefits. If the claim does not include enough information, we will ask them for more details, and they will be required to supply those details within certain timeframes.
- Out-of-Network claims can be submitted by the Provider if the Provider is willing to file on your behalf. However, if the Provider is not submitting on your behalf, you will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claims form, you can send a written request to us, or contact Member Services and ask for a claims form to be sent to you. If you do not receive the claims form, you can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:
  - Name of patient.
  - Patient's relationship with the Subscriber.
  - Identification number.
  - Date, type, and place of service.
  - Your signature and the Provider's signature.

  Out-of-Network claims must be submitted within 180 days. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 180 day period. Failure to file a claim within 180 days shall not invalidate nor reduce any claim if it was not reasonably possible to file the claim within such time, provided such proof is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time the claim is required to be filed. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask you for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your Plan.

  Please note that failure to submit the information we need by the time listed in our request could result in the denial of your claim, unless state or federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate you will be responsible for any charge for services.

Payment of Benefits

You authorize us to make payments directly to Providers for Covered Services. In no event, however, shall our right to make payments directly to a Provider be deemed to suggest that any Provider is a

beneficiary with independent claims and appeal rights under the Plan. Where permitted by applicable law, we reserve the right to make payments directly to you as opposed to any Provider for Covered Service, at our discretion. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Employer's Plan), or that person's custodial parent or designated representative. Any payments made by us (whether to any Provider for Covered Service or you) will discharge our obligation for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

Inter-Plan Arrangements

Out-of-Area Services

Overview

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve (the "Anthem Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that you obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive Covered Services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to us.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average

pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If Anthem has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan on your behalf, Anthem will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem's Service Area by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency services.

2. **Exceptions**

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core® Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core® benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan only covers Emergency including ambulance and Urgent Care outside of the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core® Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "How to Access Your Services and Obtain Approval of Benefits" section in this Booklet for further information.

How Claims are Paid with Blue Cross Blue Shield Global Core®

In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core®, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors' services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core®; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core® claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core® Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Section 11. General Policy Provisions

Assignment

Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in the "How to Access Your Services and Obtain Approval of Benefits (Applicable to Managed Care Plans)" and in "Claims Procedure (How to File a Claim)" sections.

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.

Care Coordination

We pay In-Network Providers in various ways to provide Covered Services to you. For example, sometimes we may pay In-Network Providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, we may pay In-Network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate In-Network Providers for coordination of Member care. In some instances, In-Network Providers may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by In-Network Providers to us under these programs.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Employer or us.

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of your medical information is available on our website and can be furnished to you upon request by contacting our Member Services department.

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this Booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Conformity with Law

Any term of the Plan which is in conflict with the applicable laws, will hereby be automatically amended to conform with the minimum requirements of such laws.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of the Employer. Changes are further noted in “Modifications” below this section.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

Anthem reviews and evaluates 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 Anthem’s 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

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payor, all

sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services. If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to www.Medicare.gov for more details on when you should enroll, and when you are allowed to delay enrollment without penalties.

Modifications

This Booklet allows the Plan Administrator to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Administrative Services Only Agreement, or by mutual agreement between the Plan Administrator and Anthem without the permission or involvement of any Member. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Booklet.

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 Member Services. This document is also available on our website or for in-person review at 700 Broadway in Denver, Colorado.

Not Liable for Provider Acts or Omissions

We are not responsible for the actual care you receive from any person. This Booklet does not give anyone any claim, right, or cause of action against Anthem based on the actions of a Provider of health care, services, or supplies.

Payment Innovation Programs

We pay In-Network Providers through various types of contractual arrangements. Some of these arrangements – Payment Innovation Programs (Program(s)) – may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These Programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of an In-Network Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, In-Network Providers may be required to make payment to us under the Program as a consequence of failing to meet these pre-defined standards.

The Programs are not intended to affect your access to health care. The Program payments are not made as payment for specific Covered Services provided to you, but instead, are based on the In-Network Provider's achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by us or to us under the Program(s), and you do not share in any payments made by Network Providers to us under the Program(s).

Policies and Procedures

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Administrative Services Agreement, we have the authority, in our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management, care management, or wellness initiatives which may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives

We may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Plan. The purpose of these incentives include, but is not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Relationship of Parties (Anthem and In-Network Providers)

The relationship between Anthem and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of ours, nor is Anthem, or any employee of it, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. The Plan Administrator shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

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

Right of Recovery and Adjustment

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider, or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

We have oversight responsibility for compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, we have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. Anthem reserves the right to deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Unauthorized Use of Identification Card

If you permit your Identification Card to be used by someone else or if you use the card before coverage is in effect or after coverage has ended, you will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could

be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

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) that you have not received in the recommended 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 your 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 or retailer coupons, which we encourage you to use for health and wellness related activities or items. 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 also be offered a home visit appointment to collect such specimens and complete biometric screenings. 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 or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by you, or on your behalf, to us if we have made or make payment for the services received. 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. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Subrogation and Reimbursement

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights.

- In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must promptly reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan’s rights will not be reduced due to your negligence.

- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the plan’s equitable lien applies is a plan asset.

- Any Recovery you obtain must not be dissipated or disbursed until such time as the plan has been repaid in accordance with these provisions.

- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or

2. You fail to cooperate.

- In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.

- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.

- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved and any other information requested by the plan.

- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- You must not do anything to prejudice the Plan's rights.

- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.

- You must immediately notify the plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

Anthem has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

- The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

Coordination of This Employer Contract's Benefits With Other Benefits

This coordination of benefits (COB) provision applies when you have health care coverage under more than one Plan as defined below.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, Plan has the meaning listed in the "Definitions" section.

The order-of-benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. An Out-of-Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than Our Maximum Allowable Amount.

COB DEFINITIONS

A. **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1. "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and any other federal governmental plan, as permitted by law.

   2. "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This Plan** means, in a COB provision, the part of the contract providing the health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This Plan is "Primary plan" or "Secondary plan" when you have health care coverage under more than one plan.

   When This Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When This Plan is secondary, its benefits are determined after those of another Plan and may reduced because of the Primary plan benefits, so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. **Allowable expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of

services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense.

The following are examples of non-Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses, or your stay is medically necessary in terms of generally accepted medical practice or the Hospital does not have a semi-private room.
2. If you are covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
3. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
6. The amount that is subject to the Primary high-deductible health plan's Deductible, if we have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986**.**

E. **Claim determination period** is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. You are covered by a Plan during a portion of a claim determination period if your coverage starts or ends during the claim determination period. However, it does not include any part of a year during which you have no coverage under This Plan, or before the date this COB provision or a similar provision takes effect.

F. **Closed panel plan** is a Plan that provides health benefits to you primarily in the form of services through a panel of Providers that have contracted with either directly or 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 member.

G. **Custodial parent** is the parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of payment are as follows:

1. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

1) Except as provided in paragraph 2) below, a Plan that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both Plans state that the complying Plan is primary.

2) Coverage that is obtained by virtue of membership in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.

2. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

3. Each Plan determines its order-of-benefits using the first of the following rules that apply:

1) Non-Dependent or Dependent. The Plan that covers you as other than as a Dependent, for example as an employee, member, subscriber or retiree is the Primary plan, and the plan that covers you as a Dependent is the Secondary plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent; and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order-of-benefits between the two Plans is reversed so that the Plan covering you as an employee, member, subscriber or retiree is the Secondary plan and the other plan is the Primary Plan.

2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order-of-benefits is determined as follows:

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

i. The Plan of the parent whose birthday (month and day) falls earlier in the calendar year is the Primary plan; or

ii. 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 not living together, whether or not they have ever been married:

i. If a 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. This rule applies to plan years commencing after the Plan is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of a, above shall determine the order-of-benefits;

iii. If a court 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 Dependent child, the provisions of a. above shall determine the order-of-benefits;

iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then

- The Plan covering the spouse of the non-custodial parent.

c. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of a. and b. above will determine the order-of-benefits as if those individuals were the parents of the child.

3) Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering you as a retired or laid-off employee is the Secondary plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if 4. 1) above can determine the order-of-benefits.

4) COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by state or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule for 4. 1) from above can determine the order of benefits.

5) Longer or Shorter Length of Coverage. The Plan that covers you as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the plan that covers you for the shorter period of time is the Secondary plan.

6) If the preceding rules do not determine the order-of-benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of the other health care coverage.

B. If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We need not divulge, or get the consent of, any person to do this. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by us is more than it should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Section 12. Termination/Nonrenewal/Continuation

Because the Plan provides you with multiple health care options, eligible employees may change coverage for themselves and/or their eligible Dependents to another benefit Plan offered by the Plan during Open Enrollment.

Termination

Active Policy Termination
Your benefits end on the first occurrence of one of the following events:

- On the date the Plan described in this Booklet is terminated.
- Upon the Subscriber's death.
- When the required contribution has not been received by the employer.
- When you or your employer commits fraud or intentional misrepresentation of material fact.
- When you are no longer eligible for benefits under the terms of this Booklet.
- When the Subscriber's employer gives Us written notice that the Subscriber is no longer eligible for benefits. Benefits will be terminated as determined by the employer. We reserve the right to recoup any benefit payments made for dates of service after the termination date.
- When We receive written notification to cancel coverage for any Member, benefits will end at the end of the month following the written notification or at the end of the month of the qualifying event.
- When you move and therefore do not reside within the Service Area unless you are continuing coverage under COBRA/continuation coverage, you must notify your employer 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 and non-Urgent care will not be covered.
- If you do not notify your employer of a change of residence to an area outside Our Service Area, and We later become aware of the change, your benefits may be retroactively terminated to the date of the change of residence. You will be liable to Us and/or the Providers for payment for any services covered in error.
- 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. 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.
- When We cease operations.

Dependent Coverage Termination
To remove a Dependent from the Plan, the Subscriber must complete a Benefits Enrollment/Change Form or online submission. The change will be effective at the end of the month We are notified of the change. We reserve the right to recoup any benefit payments made after the termination date.

Benefits for a Dependent end on the last day of the month for the following qualifying events:

- When the Subscriber's employer notifies Us in writing to cancel benefits for a Dependent.
- When the Dependent child no longer qualifies as a Dependent by definition. Such a Dependent may be able to elect COBRA/continuation coverage.
- On the date of a final divorce decree or legal separation for a Dependent Spouse or Partner. Such a Dependent may be able to elect COBRA/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. 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.
- When legal custody of a child placed for adoption is terminated.
- Death of the Dependent.

What We Will Pay for After Termination

We, on behalf of the Plan, will not authorize payment for any services provided after your benefits end even if we preauthorized the service, unless prohibited by law. Benefits cease on the date your participation ends as described above. You may be responsible for benefit payments authorized by Us on your behalf for services provided after your benefits have been terminated.

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

- We preauthorized the service; and/or
- The services were made necessary by an accident, illness or other event that occurred while benefits were in effect.

Continuation of Benefits

Family and Medical Leave Act
When an employee takes time off from work pursuant to the Family and Medical Leave Act, health insurance benefits remain in force but the employee may be required to continue paying the employee's share of the cost of such health benefits. You may contact your employer for details.

COBRA Continuation Rights Under Federal Law
Continuation Coverage For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended and the parallel continuation coverage requirement under the Public Health Service Act ("COBRA"), you and/or your Dependents will be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that Plan's coverage area or the Plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- Your termination of employment for any reason, other than gross misconduct.
- Your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- Your death.
- Your divorce or legal separation.
- Your entitlement to Medicare (Part A, Part B, or both).
- For a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?
Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals, who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation. Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension for Your Dependents" are not applicable to these individuals.

The following individuals may not be qualified beneficiaries for purposes of COBRA continuation (unless they meet the federal definition of "qualified beneficiary": partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you), and children of a partner. However, they may be eligible through your employer for continuation coverage under the same time conditions and time periods as COBRA.

Secondary Qualifying Events
If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; you become entitled to Medicare benefits (under Part A, Part B or both); or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension
If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) or the Public Employees' Retirement Association (PERA) Disability Program Administrator to be totally disabled under Title II or XVI of the Social Security Act, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event. To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA/PERA must determine that the disability occurred during the first 60 days after the disabled individual elected COBRA continuation coverage.
- A copy of the written SSA/PERA determination must be provided to the COBRA Plan Administrator within 60 calendar days after the date the SSA/PERA determination is made AND before the end of the initial 18-month continuation period. If the SSA/PERA later determines that the individual is no longer disabled, you must notify the COBRA Plan Administrator within 30 days after the date the final determination is made by SSA/PERA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA/PERA makes a final determination that the disabled individual is no longer disabled. All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents
When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA/Continuation Coverage
COBRA/continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA/continuation period of 18, 29 or 36 months, as applicable.
- failure to pay the required premium within 30 calendar days after the due date.
- when the Plan ceases to provide any group health plan, including successor plans to any employee.
- after electing COBRA/continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both); after electing COBRA/continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage. In such case coverage will continue until the earliest of: the end of the applicable maximum period; or the occurrence of an event described in one of the first three bullets above.
- any reason the Plan would terminate coverage of a Member or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Your CU Health Plan's Service Area or Elimination of a Service Area
If you and/or your Dependents move out of this Plan's Service Area or this Plan eliminates a Service Area in your location, you may elect to continue COBRA/continuation coverage under another CU Health Plan you are eligible for, otherwise your COBRA/continuation coverage under the Plan will be limited to emergency and urgent services only. Because the Plan does not provide out-of-network coverage, nonemergency and non-urgent services will not be covered under the Plan outside of its Service Area.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the your employer within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation.
- Your child ceases to qualify as a Dependent under the Plan.

The occurrence of a secondary qualifying event is discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period). (Also refer to the section titled "Disability Extension" for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Member covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

COBRA/Continuation for Retirees Following Employer's or Trust's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to your employer or the Trust under Title 11 of the United States Code, you may be entitled to COBRA/continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

Health Coverage Tax Credit ("HCTC")

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Members who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). The Trade Adjustment Assistance Extension Act of 2011 increased the amount of the HCTC, expanded those eligible to receive it, and extended the COBRA coverage. Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1- 866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the HCTC is also available at www.irs.gov by entering the keyword "HCTC." In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under "Termination of COBRA Continuation" above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify your employer immediately.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

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.

Section 13. 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 Plan or a service you have received. In those cases, please contact Member Services by calling the Member Services telephone number on the back of your 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 your complaint, you have the right to file a Grievance / Appeal, which is defined as follows:

We may have turned down your claim for benefits, your continuity of care request, or your request to cover a Drug as an exception to the Prescription Drug List. 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 have a Complaint about any aspect of Our service or claims processing, you should contact Our Member Services department. A trained representative will work to clear up any confusion and resolve your concerns. You may submit a written Complaint to the address listed below. If you are not satisfied with the resolution of Member concerns by Our Member Services associate, you may file an Appeal at these addresses as explained under the **Appeals** heading in this section:

For Medical Services: Anthem Blue Cross and Blue Shield

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

For Prescription Services:

Prescription Claim Appeals

MC 109 - CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax: 1-866-443-1172

Appeals

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

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial; and
- you are entitled to a full and fair review of the denial.

The procedure Anthem will satisfy following the minimum requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

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

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

For claims involving urgent/concurrent care:

- Anthem's notice will also include a description of the applicable urgent/concurrent review process; and
- Anthem may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

Appeals

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

- Anthem shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including Anthem's decision, can be sent between Anthem and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact Anthem at the phone number listed on your Health Benefit ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;

- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

For services that are **not** for Mental Health Conditions, Alcohol Dependency or Substance Dependency:

Anthem Blue Cross and Blue Shield

Appeals Department
700 Broadway
Mail Stop CO0104-0430
Denver, CO 80273

For services that are for Mental Health Conditions, Alcohol Dependency or Substance Dependency:

Anthem Blue Cross and Blue Shield

Appeals Department
700 Broadway
Mail Stop CO0106-0642
Denver, CO 80273

You must include Your Member Identification Number when submitting an appeal.

Upon request, Anthem will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

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

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

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When Anthem considers your appeal, Anthem will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care

professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

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

If you appeal any other pre-service claim, Anthem will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal

If you appeal a post-service claim, Anthem will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

- If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from Anthem will include all of the information set forth in the above subsection entitled "Notice of Adverse Benefit Determination."

Voluntary Second Level Appeals

If you are dissatisfied with the mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to Anthem within four (4) months of the notice of your final internal adverse determination.

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

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

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and

- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless Anthem determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield
700 Broadway
Mail Stop CO0104-0430
Denver, CO 80273

You must include Your Member Identification Number when submitting an appeal.

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

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan.

If your health benefit Plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the appeal decision.

The Plan reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

Grievances

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

For medical and prescription drug or pharmacy issues:

Anthem Blue Cross and Blue Shield
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.

Section 14. Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Member Services at the Member Services telephone number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Administrative Services Agreement

The agreement between HMO Colorado and the employer, regardless of how such an agreement may be titled, stating all the terms and provisions applicable to the administration of this Plan.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Applied Behavioral Analysis

The use of behavior analytic methods and research findings to change socially important behaviors in meaningful ways.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will not have to pay any more than the In-Network Deductible, Coinsurance, and/or Copayment(s) that apply. Please see "Claims Procedure (How to File a Claim)" for more details.

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 disorders, as defined in the most recent edition of the diagnostic and statistical manual of mental disorders in effect at the time of the diagnosis: autistic disorder, Asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified.

Autism Treatment Plan

A plan for a Member by an Autism Services Provider and prescribed by a Doctor or psychologist in line with 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 Maximum

The number of days or units of Covered Services, such as two office visits per your Benefit Period, for which a health coverage will provide benefits during a specified length of time.

Benefit Period

The length of time we will cover benefits for Covered Services (July 1 through June 30). If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Biosimilar/Biosimilars

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

Booklet

This document (also called the Benefit Booklet), which describes the terms of your benefits.

Brand Name Drugs

Prescription Drugs that we classify as Brand Drugs or that our PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Chiropractic Care / Manipulative Therapy

A system of therapy that includes the therapeutic application of manual manipulation treatment, analysis and adjustments of the spine and other body structures, and muscle stimulation by any means, including therapeutic use of heat, cold, and exercise.

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.

Claims Administrator

An organization or entity that the employer contracts with to provide administrative and claims payment services under the Plan. The Administrator of this Plan is Anthem Blue Cross and Blue Shield. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Complications of Pregnancy

Complications of Pregnancy means:

- Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. This does not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy;
- Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

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.

Controlled Substances

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a $15 Copayment for an office visit, but a $150 Copayment for Emergency Room Services.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if Precertification or prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

Please see the "Benefits/Coverage (What is Covered)" section for details.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,

- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won't cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility" section and who has enrolled in the Plan.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Doctor

See the definition of "Physician."

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "Benefits/Coverage (What is Covered)" section.

Emergency Care

Please see the "Benefits/Coverage (What is Covered)" section.

Employer

An Employer who has allowed its Employees to participate in the Plan by acting as the Plan Sponsor or adopting the Plan as a participating Employer by executing a formal document that so provides. The Employer or other organization has an Administrative Services Agreement with Anthem to administer this Plan.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

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

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

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

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use;
- Is provided as part of a clinical research protocol or clinical trial (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.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable or meet specific rules set by us.

Fee(s)

The amount you must pay to be covered by this Plan.

Generic Drugs

Prescription Drugs that we classify as Generic Drugs or that our PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Habilitative Services

Habilitative Services help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

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 Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by The Joint Commission.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care

2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care

Identification Card

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see “How to Find a Provider in the Network” in the section “How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)” for more information on how to find an In-Network Provider for this Plan.

In-Network Transplant Provider

Please see the “Benefits/Coverage (What is Covered)” section for details.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive In-Home Behavioral Health Services

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week.

Interchangeable Biologic Product

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

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 pain.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the “Eligibility” section for further details.

Maintenance Medications

Please see the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section for details.

Maintenance Pharmacy

An In-Network Retail Pharmacy that is contracted with our PBM to dispense a 90 day supply of Maintenance Medication.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the “Member Payment Responsibility” section.

Medical Necessity (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 or the same intervention in an alternative setting. 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. For example we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a Physician’s office or the home setting;
- 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.

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called “you” and “your” in this Booklet.

Mental Health and Substance Abuse (Behavioral, Mental Health and Substance Use Disorder)

A condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of (a) the international statistical classification of diseases and related health problems; (b) the Diagnostic and Statistical Manual of Mental Disorders (DSM); or (c) the

diagnostic classification of mental health and developmental disorders of infancy and early childhood. The phrase also includes Autism Spectrum Disorders, as defined in this Booklet.

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the “Eligibility” section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

Benefits are not available when you use Out-of-Network Providers, unless they are for Emergency or Urgent Care or for services approved in advance by Anthem as an Authorized Service.

Out-of-Network Transplant Provider

Please see the “Benefits/Coverage (What is Covered)” section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include your Fee, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn’t cover.

Partial Hospitalization Program

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on Anthem’s behalf. Anthem’s PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

The management and other services the PBM provides include, but are not limited to: managing a network of Retail Pharmacies and operating a mail service Pharmacy. Anthem’s PBM, in consultation with Anthem, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,

- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The Plan Administrator's benefit plan, which is described in this Booklet.

Plan Administrator

The entity (employer) which is responsible for the administration of the plan. ***The Plan Administrator is not Anthem.***

Precertification

Please see the section "How to Access Your Services and Obtain Approval of Benefits" for details.

Prescription Drug (Drug) (Also referred to as Legend Drug)

A medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1. Compounded (combination) medications, when all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
2. Insulin, diabetic supplies, and syringes.

Prescription Order

A written request by a Provider, as permitted by law, for a Prescription Drug or medication, and each authorized refill.

Primary Care Physician / Provider ("PCP")

A Provider who gives or directs health care services for you. The Provider may work in family practice, general practice, internal medicine, pediatrics or any other practice allowed by the Plan. A PCP supervises, directs and gives initial care and basic medical services to you and is in charge of your ongoing care.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet please call the Member Services telephone number on the back of your Identification Card.

Referral

A written authorization form received from your PCP or from us in advance of the services that allows you to receive Covered Services from a Provider other than your PCP. Please see the "How to Access Services and Obtain Approval of Benefits" section for details.

Residential Treatment Center / Facility:

A Provider licensed and operated as required by law, which includes:

1. Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability.
2. A staff with one or more Doctors available at all times.
3. Residential treatment takes place in a structured facility-based setting.
4. The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
5. Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
6. Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area, which is the state of Colorado, where you can get Covered Services from an In-Network Provider.

Site of Service Provider

Site-of-Service (SOS) Providers are surgical, lab, radiology and diagnostic imaging centers that meet cost and other criteria established by Anthem. They are:

- A Provider that is not part of or owned by a Hospital and bills independently (i.e. not under a Hospital’s name or ID number.) Providers such as Radiology Providers, Reference Laboratories, and Ambulatory Surgery Centers meet these criteria and are considered “freestanding” Site-of-Service Providers.
- An outpatient Facility location owned by a Hospital that is contracted with Anthem and meets the criteria to be considered “Site-of-Service” (“SOS”).

These entities provide health care services such as surgery, laboratory tests, radiology and other services that are typically lower cost options for patients. Each participating Facility is subject to specific licensing, accreditation and credentialing requirements.

Skilled Nursing Facility

A duly licensed Facility operated alone or with a Hospital that cares for you when you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and accredited by The Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, or a place for rest, educational, or similar services.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

An employee or member of the Employer who is eligible for and has enrolled in the Plan.

Transplant Benefit Period

Please see the “Benefits/Coverage (What is Covered)” section for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

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 Medical Booklet

Get help in your language

Curious to know what all this says? We would be too. Here's the English version: You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone Member Services telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian
Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711).

Bassa
Ǹ ɓéɖé dyí-ɓèɖèìn-ɖèɔ ɓé m̀ ké bɔ̃ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Đá méɓà jè gbo-gmɔ̀ Kpòè nɔɓà nìà nì Dyí-dyoìn-bɛ̃̂ɔ̃ kɔ̃ɛ ɓé m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali
আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।(TTY/TDD: 711)

Burmese
ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရရှိင်ခွင့် သင့်တွင်ရှိပါသည်။
အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။
(TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。
(TTY/TDD: 711)

Dinka
Yin nɔŋ yic ba ye lëk në yök ku bë yi kuɔny në thöŋ yin jäm ke cin wëu töu kë piiny. Cɔl rän töŋ dë kɔc kë luɔi në nämba dën tɔ̈ në I.D kat du yic. (TTY/TDD: 711)

Dutch
U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

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

French
Vous avez le droit d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d’identification. (TTY/TDD: 711)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek
Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati
તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઈડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કૉલ કરો. (TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi
आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano
Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian
Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មានេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi
Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao
ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ
ຄວາມຊ່ວຍເຫຼືອປະນຳສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານ
ຫຼືຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo
Bee n1 ahoot'i' t'11 ni nizaad k'ehj7 n7k1 a'doowo[t'11 j77k'e. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. (TTY/TDD: 711)

Nepali
तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्। (TTY/TDD: 711)

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch
Du hoscht die Recht selle Information un Helfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Helfe aa. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe
Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian
Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apelați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan
E iai lou ‘aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian
Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian
Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu
آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔(TTY/TDD:711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish
רופט די מעמבער איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. באדינונגען נומער אויף אייער קארטל פאר הילף (TTY/TDD:711)

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)

It's important we treat you fairly

It's important that we treat you fairly. That's why Anthem and the University of Colorado Health and Welfare Plan follows federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Section 15. Thank You from Anthem

The medical benefits described in this Booklet are paid by CU Health Plan. Anthem Blue Cross and Blue Shield ("Anthem") provides administrative claims payment services as described before this page.

Prescription Drug Coverage described after this page is administered by CVS Caremark after this page and does not obligate Anthem to provide or pay for any additional benefits or services.

Thank you for selecting Anthem Blue Cross and Blue Shield for your medical health care coverage.

Section 16. Prescription Benefits Administered by CVS Caremark

Benefits in this section are subject to the **RETAIL PHARMACY/MAIL ORDER PRESCRIPTION DRUGS EXCLUSIONS** section at the end of this section of the booklet.

If you enroll in medical coverage, you automatically receive prescription drug benefits administered by CVS Caremark.

How Prescription Drug Benefits Work

To be eligible for coverage, a prescription drug must be:

- Necessary for the treatment of a disease or illness and widely accepted as effective, appropriate and essential – based on the recognized standards of the medical community,
- Prescribed by a licensed physician, and
- Prescribed in accordance with type, frequency and duration-of-treatment guidelines of national medical, research and governmental agencies.

Visit the CVS Caremark website (www.caremark.com) or call CVS Caremark at 1-888-964-0121 for the generic, brand, (preferred or non-preferred) and specialty listing that describes those prescription drugs that are eligible and ineligible for reimbursement under the CU Health Plan prescription drug program. If you have any questions about a particular prescription, call CVS Caremark. The fact that your physician prescribes, orders, recommends, or approves a prescription or supply does not automatically mean it is an eligible expense. Always call CVS Caremark to confirm coverage.

The program offers coverage for both your short-term and long-term prescription needs. When you have prescriptions filled at a retail pharmacy, benefits are payable for up to a 30-day supply. To receive prescription drug benefits, you and your covered dependents may pay a portion of the covered expenses for prescription drugs and related supplies for each 30- day supply at a retail pharmacy. That portion is the copayment, deductible or coinsurance.

The CVS Caremark network includes many retail pharmacies, including major chain pharmacies and independent community pharmacies. To locate a participating pharmacy either call CVS Caremark directly at 1-888-964-0121 or to find the pharmacy closest to you, go to www.caremark.com.

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

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 need to pay the cost difference between the Generic and Brand Name Drug in addition to your pharmacy tier copayment. The cost difference between the Generic and Brand Name Drug does not contribute to 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.

The Covered Services under this section do not include those received in the Hospital as an Inpatient. Refer to the **INPATIENT SERVICES** section for services covered by the Booklet. For medications or equipment not obtained through a pharmacy, see the **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES** section of this Booklet. For Prescription Drugs, including Specialty Pharmacy Drugs, which are administered to you in a medical setting (e.g., Physician's office, home care visit, or outpatient Facility), see **PRESCRIPTION DRUGS ADMINISTERED BY A MEDICAL PROVIDER** section for more information.

You may fill your prescriptions through the UCHealth Retail Pharmacies, or through one of CVS Caremark's Participating Retail Pharmacies. Mail Order prescriptions are managed by the University of Colorado Hospital Mail Order Prescription Service.

We have established a Pharmacy and Therapeutics (P&T) Process, in which health care professionals, 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, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives and drug profiling initiatives.

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.

You may review the current formulary drug list on Our website at www.caremark.com/acsdruglist. You may also request a copy of the formulary drug list by calling the CVS Caremark Customer Service. The formulary drug list is subject to quarterly review and amendment. Inclusion of a drug or related item on the formulary drug list is not a guarantee of coverage.

When you have your prescription filled at one of Our Retail Pharmacies, benefits available under this Booklet are managed by the Pharmacy Benefits Manager (PBM), CVS Caremark, which offers a nationwide network of Pharmacies and clinical services.

For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before We will determine Medical Necessity. We may, at Our sole discretion, establish quantity limits for specific Prescription Drugs.

Your Deductible and/or Copayment amount depends upon which tier the Prescription Drug falls under as follows:

- **Tier-1** – Generic Drugs.
- **Tier-2** – Brand Name Prescription Drugs.
- **Tier-3** – Non-preferred Brand Name Prescription Drugs.
- **Tier-4**– Specialty Drugs.

See the *Summary of Benefits and Coverage* to determine the associated Copayment for each tier.

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

Certain Prescription Drugs (or the prescribed quantity of a particular drug) may require prior authorization. At the time you fill a prescription, the In-Network pharmacist is informed of the prior authorization requirement through the pharmacy's computer system, and the pharmacist is instructed to contact CVS Caremark. To check if your drug has a prior authorization requirement please login to www.caremark.com and use the Check Drug Cost tool.

The Provider or pharmacist can check with Us to verify drug placement, any quantity limits, Step-Therapy, prior authorization requirements, or appropriate Brand or Generic drugs recognized under the Booklet.

Therapeutic substitutions may also be initiated at the time the prescription is dispensed. Only you and the Physician together can determine whether the therapeutic substitute is appropriate for you.

Outpatient pharmacy benefits received from a retail pharmacy or Mail-Order 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. Members diagnosed with diabetes may be eligible to have diabetic medication filled with no Copayment. Please contact Customer Service for additional information.
- Oral contraceptive drugs and contraceptive devices. Certain contraceptives are covered under Preventive Care Services.
- Certain supplies, equipment and appliances (such as those for diabetes and asthma). 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.
- 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 Deductible and/or Copayment. If the prescription order includes more than one covered drug or supply, a separate Deductible and/or Copayment is required for each covered drug or supply. The Deductible and/or Copayment is based on the Prescription Drug Maximum Allowed Amount. The Deductible and/or Copayment will not be reduced by any discounts, rebates or other funds received by UCHealth, Us or the PBM from drug manufacturers, or similar vendors and/or funds received by UCHealth, Us and or the PBM. We will make no payment for any covered drug or supply unless the Prescription Drug Maximum Allowed Amount exceeds any applicable Deductible and/or Copayment for which you are responsible.

See the Summary of Benefits and Coverage to determine the associated Deductible and/or Copayment.

You are limited to up to a 30-day supply of a prescription drug if obtained at a Retail Pharmacy or up to a 90-day supply if received through the UCH Mail Order Prescription Service Pharmacy. For oral contraceptives, you are limited to one pill pack (normally 28 days) at a Retail Pharmacy, or three pill packs by the UCH Mail Order Prescription Service Pharmacy. When Medically Necessary, a one-month vacation override is available with applicable Deductible and/or Copayment and quantity restrictions if you are traveling out of Our Service Area.

For a list of In-Network Pharmacies see our website at www.caremark.com.

Specialty Pharmacy Drugs

Specialty Pharmacy Drugs are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at a Retail Pharmacy or through a Mail Order Pharmacy. Specialty Pharmacy Drugs are available from UCHealth Pharmacies. Certain Specialty Drugs may be filled at CVS Specialty Pharmacy if UCHealth Pharmacies do not have them in stock. If Specialty Pharmacy Drugs are purchased from a Retail Pharmacy they will be considered as Out-of-Network and not covered.

The Outpatient Specialty Pharmacy benefits available under this Booklet may be managed by CVS Caremark, the Pharmacy Benefits Manager (PBM). A Specialty Pharmacy is not a Retail Pharmacy or a Home Delivery Pharmacy.

We use many different administrative processes and tools. These help Us decide the most appropriate use and cost- effective alternatives available to Our Members. All Specialty Pharmacy Drugs will require prior authorization. At the time you fill a prescription, you will be informed if prior authorization is needed. For a list of current drugs requiring prior authorization, contact CVS Caremark Customer Service, or reference the Check Drug Cost tool at www.caremark.com.

It is your responsibility to assure that Preauthorization has been obtained prior to filling a Specialty Drug Prescription for the drug to be a covered benefit. Specialty drugs are limited to a 30 day supply. After 3 fills from a Retail Pharmacy the prescription must the filled by a UCHealth Pharmacy. A list of the Specialty Pharmacy Drugs that are covered is available from Our Member Services department or may be found on Our website at www.caremark.com/acsdruglist.

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

You or your Doctor may order your Specialty Pharmacy Drug from the UCHealth 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 Deductible and/or 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.

If you or your Provider believe that you should not be required to get your Specialty Pharmacy Drugs from a Specialty Pharmacy, you must follow the exception process. Please call CVS Caremark customer service to being the exception process.

Mandatory Mail Order Pharmacy for Maintenance Drugs

You may also purchase your maintenance medication by utilizing the University of Colorado (UCH) Mail Order Prescription Service. If you are taking Maintenance Drugs you are limited to an initial 30 day supply and up to two subsequent 30-day refills of the Maintenance Drugs from a UCHealth Retail Pharmacy or Participating Retail Pharmacy. After this 90 day period you must be using the Mandatory Mail Order Program through the UCH Mail Order Prescription Service to purchase future Maintenance Drugs. A short-term drug, like an antibiotic, would not be considered a Maintenance Drug and therefore you could fill your prescription at a local retail pharmacy. Ordering your Maintenance Drugs through the UCH Mail Order Prescription Service mandatory mail order program eliminates the need for monthly trips to the pharmacy by having your prescriptions delivered directly to your home. Specialty Prescription Drugs, both Oral and Injectable, are not available through the mandatory mail order pharmacy program.

The Mail Order Pharmacy drugs benefits available under this Booklet are managed by the University of Colorado Hospital Mail Order Prescription Service at:

University of Colorado Hospital Mail Order Prescription Service

12605 E. 16th Avenue,
Mail Stop A014 Aurora,
CO 80045

Phone (720) 848-1432

Fax (720) 848-1433

A Prescription Drug must be a Legend Drug to be eligible for benefits.

To receive your maintenance medicine prescription by mail, follow these steps. You can locate the UCH Prescription Service Form at www.uchealth.org/services/pharmacy.

- Ask your doctor to prescribe a 90-day supply of your maintenance medicine plus refills (certain medications will be subject to state or federal dispensing limitations). If you need the medicine immediately, ask your doctor for two prescriptions, one to be filled right away and another to be sent to the UCH Mail Order Prescription Service Pharmacy.
- Mail your written prescription(s), and a check to cover the amount of your Deductible and/or Copayment to the University of Colorado Hospital Mail Order Prescription Service. Credit card, money orders, debit card or checks are acceptable.

Please allow 10-14 days for processing and shipping of your order.

Helpful Tip: We suggest that you order your refill two weeks before you need it to avoid running out of your medication. Any questions concerning the mail-order program, contact University of Colorado Hospital Mail Order Prescription Service at 720-848-1432 or 1-800-941-2207 if you are outside the Denver metro area.

You will receive refill forms and a notice that shows the number of refills your doctor ordered in the package with your drugs. To order refills, you must have used 75% of your mail order prescription.

When you may need to file a claim

You may need to file your own claim if:

- The pharmacy you fill your prescriptions at is not able to file the claim electronically.
- You need to have a prescription filled before you receive your Health Benefit ID Card.
- Your Physician increases the amount of your dosage.

Retail Pharmacy/Mail Order Prescription Drugs Exclusions:

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 or Non-formulary Prescription Drugs.
4. 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®, finasteride.
5. Drugs not approved by the FDA.
6. Any medications used to treat infertility.
7. Delivery charges for prescriptions.
8. Charges for the administration of any drug unless dispensed in the Physician's office or through Home Health Care.
9. Drugs which are provided as samples to the Provider.
10. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse.
11. Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of the **RETAIL PHARMACY/MAIL ORDER PRESCRIPTION DRUGS** section.
12. Therapeutic devices or appliances, including support garments and other non-medicinal supplies (regardless of intended use).
13. 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.
14. 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.
15. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) except for injectable insulin, or where applicable law requires covered of the drug.
16. Prescription Drugs, which are dispensed in quantities or refill frequency which exceed the applicable limits established by Us, at Our sole discretion.
17. Refills of prescriptions in excess of the quantity or refill frequency prescribed by the Provider, or refilled more than one year from the date prescribed.
18. Prescription Drugs dispensed for the purpose of international travel.

19. Prescription Drugs which have been obtained through a Home Health Agency.
20. Maintenance drugs after a total of a 90 day supply that have been purchased an In-Network pharmacy. All maintenance drugs received after your initial 90 day supply must be purchased from the University of Colorado Hospital Mail Order Prescription Service to be covered.
21. 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.
22. When benefits are provided for Prescription Drugs under the **PRESCRIPTION BENEFITS ADMINISTERED BY CVS CAREMARK** section, they will not also be provided under the **PRESCRIPTION DRUGS ADMINISTERED BY A PROFESSIONAL PROVIDER** section.

Outpatient Pharmacy Prescription Appeals

Once a member or member's representative is notified that a claim is wholly or partially denied (an adverse determination), he or she has the right to appeal. Appeals may be based on an adverse benefit determination from an initial clinical review or an adverse non-clinical determination from an initial non-clinical review. Appeal requests must be submitted to the Appeals department by fax, mail or phone within 180 days after receiving an adverse determination notification. Urgent appeals may be submitted by phone or in writing. Non-urgent appeals may be submitted in writing by fax or mail.

Once an appeal is received, the appeal and all supporting documenting are reviewed and completed, including a notification to the member and physician, within the following timelines:

- Urgent Pre-Service Appeal: 72 hours
- Non-Urgent Pre-Service Appeal: 15 days
- Post-Service Appeal: 30 days

Review of Adverse Benefit Determinations First-Level Clinical Appeal

First-level appeals are reviewed against predetermined medical criteria relevant to the drug or benefit being requested. This includes the consideration of relevant and supporting documentation submitted by the member or the member's authorized representative. Supporting documentation may include a letter written by the practitioner in support of the appeal, a copy of the denial letter sent by CVS Caremark, a copy of the member's payment receipt, medical records, etc. The appeal will be reviewed by an appropriately qualified reviewer. If the denial is upheld by the appeal, a denial notification will be sent to the member with instructions on how to request a second-level Medical Necessity review.

If a member's appeal is urgent, CVS Caremark will perform both the first-level and second-level review as a combined appeal review within the designated timeframes. If the first-level request is approved, no further review is required and a notice of approval will be sent to the member. If the first-level review cannot be approved, a second-level Medical Necessity review will be initiated automatically. The member will receive notice of the determination at the conclusion of the Medical Necessity review. The two levels are combined in order to meet the designated urgent appeal timeframe.

Second-Level Medical Necessity Appeals

If the first-level appeal denial is upheld, the member or the member's authorized representative may choose to pursue a second-level appeal. The second-level appeal consists of a review to determine if the requested drug or benefit is medically necessary. These requests are reviewed either by an appropriately qualified reviewer or a

sub-delegated medical necessity review organization (MNRO). If a member's appeal is urgent, CVS Caremark will perform the second-level review within the designated urgent appeal timeframe.

For appeals reviewed by the MNRO, the following will occur:

- CVS Caremark will forward applicable medical records, PA and appeals documentation, plan language and specific criteria to the MNRO.

- The independent physician reviewer selected by the MNRO to conduct the review will evaluate the provided documentation received with the case. If the physician reviewer determines additional information is necessary or potentially useful in the review, the physician reviewer may contact the member's physician to request such information.
- The independent physician reviewer will review current medical literature and available medical records and any additional information obtained from the prescribing physician. The independent physician reviewer will write an independent rationale in support of his or her final decision.
- The letter containing the rationale will be forwarded to CVS Caremark for communication to the member or the member's representative.

Review of Adverse Non-Clinical Determinations

CVS Caremark provides a single-level appeal for non-clinical appeals. Upon receipt of a non-clinical appeal, CVS Caremark will review the member's request for a particular drug or benefit against the terms of the Plan, including the preferred drug lists, formularies or other defined plan benefits selected by the Plan Sponsor or in the PDD. A non-clinical appeal will not involve an assessment of whether the requested drug or benefit is medically necessary.

Appeal Determination Process

Appeals and associated documentation are stamped with the date and time of receipt. Reviews are conducted within the applicable timeframes previously mentioned in this document. The appeal determination is rendered, and pertinent information is entered into the database. The determination is then communicated in writing to the member or the member's representative.

Communications are written in a manner to be understood by the member or the member's representative. Communications include:

- The specific reason(s) for the determination
- A reference to pertinent Plan provision on which the determination was based
- A notice that the member can submit a written request for the following at no cost: copies of all documents, records and other information relevant to the claim
- A copy of the specific rule, guideline, protocol or other similar criterion that was relied upon in making the determination, if applicable; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request
- An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, if the Adverse Benefit Determination or Appeal of Adverse Benefit Determination is based on a Medical Necessity; or a statement that such explanation will be provided free of charge upon written request
- A statement of the member's right to bring action under (Employee Retirement Income Security Act) ERISA Section 502(a), if applicable
- A description of the available internal appeals process and external review process, if available.
- Information regarding the applicable office of health insurance consumer assistance or ombudsman established under the Section 2793 of the Public Health Services Act to assist individuals with internal claims and appeals and external review

Confidentiality

All member and client appeal documentation is handled in a confidential manner and in accordance with applicable statutes and regulations to protect the member's identity and his or her prescription history. To maintain confidentiality of member information, all appeal information becomes a part of a permanent case file.

Outpatient Pharmacy Prescription Definitions

CVS Caremark – the prescription benefit manager for this plan. Also referred to in this Booklet as “CVS”, “Us”, “We” or “Our”, as applicable to prescription services.

Prescription Drugs - Prescription Drugs include:

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

Formulary - a list of pharmaceutical products developed in Consultation with Physicians and pharmacists and approved for their quality and cost-effectiveness. You may view a copy of the preferred formulary drug online or request a hard copy of the list by calling Our Member Services department. The preferred formulary drug list is subject to periodic review and amendment.

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

Legend Drug - a medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug

& Cosmetic Act is required to 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.

Maintenance Drugs - medications that are prescribed for chronic, long-term conditions and are taken on a regular, recurring basis. Examples of chronic conditions that may require Maintenance Drugs are high blood pressure, high cholesterol, epilepsy and diabetes.

Pharmacy - an establishment licensed to dispense Prescription Drugs and other medications by a licensed pharmacist upon an authorized health care Provider’s order. A pharmacy may be an In-Network Provider or an Out-of-Network Provider. An In-Network pharmacy is contracted as an In-Network pharmacy with Us to provide covered drugs to you under the terms and conditions of this Booklet. An Out-of-Network pharmacy is **not** contracted with Us.

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

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

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 provided to Us by the Pharmacy Benefits Manager (PBM).

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.

End of Outpatient Prescription Drug Booklet