Funded by the University of Colorado Health and Welfare Trust

Health Plan
Medicare

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.

Important Note

This Booklet is not a Medicare Supplement policy. If you are eligible for Medicare, please review the "Guide To Health Insurance for People With Medicare" available at www.medicare.gov or from Medicare.

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.

Section 4. Table of Contents

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

Benefits under this Booklet will be the Medicare allowed amount for those services covered by Medicare up to Our Maximum Allowed Amount. Medicare is the primary payer for this Plan, and Covered Services payable under this Plan will be reduced by the amounts payable for the same expenses under Medicare Parts A and B. Members enrolled under this Booklet will be considered enrolled under Medicare Parts A and B. If the medical service or supply is not covered under Medicare then it is not a covered benefit under this Plan unless otherwise indicated.

Any preauthorization requirements will be determined by Medicare unless a service is not covered by Medicare and is covered under this Booklet. In those situations preauthorization may be required.

Preauthorization is a process We use to ensure that your care is provided in the most medically appropriate setting. The Preauthorization process may set limits on the coverage available under this Booklet. Preauthorization is required before a Hospital admission or before receiving certain procedures or services. Some drugs also require Preauthorization.

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

Contracted Providers will bill Us directly and accept Our Maximum Allowed Amount as payment in full. The Maximum Allowed Amount is the dollar amount approved by Us for a specific covered service. For those services not covered by Medicare but that are covered under this Booklet, you are responsible for determining if your Provider is a contracted Provider.

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

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.

Section 7. Benefits/Coverage (What is Covered)

Any benefits payable under this Booklet for you and your Medicare eligible Dependent will be reduced by the amounts payable for the same expense under Medicare Parts A and/or B. This means Medicare will pay their benefits first and will be the primary payer of benefits. Covered Services and supplies are only benefits if they are Medically Necessary or preventive, not otherwise excluded under this Booklet as determined by Us in administering the Plan, and obtained in the manner required by this Booklet.

All benefits are subject to Medicare allowable covered guidelines which are described below. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment by Us.

If Medicare covers the service or supply the allowance will be determined by Medicare. If the provider accepts Medicare assignment, you are not responsible for any amounts that are more the allowance Medicare allows. If Medicare does not cover a service or supply, then it is not a covered service except as provided below and it is subject to the terms of the this Booklet.

Clinical Trials

If Medicare does not cover a service or supply, then it is not a covered service except as provided below.

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

If Medicare does not cover a service or supply, then it is not a covered service except as provided below.

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

If Medicare does not cover a service or supply, then it is not a covered service except as provided below.

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.

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

If Medicare does not cover a service or supply, then it is not a covered service except as provided below.

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 Medicare does not cover a service or supply, then it is not a covered service except as provided below.

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 be covered at the Out-of-Network level unless we agree to cover them as an Authorized Service.

Home Care Services

If Medicare does not cover a service or supply, then it is not a covered service except as provided below.

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.

Hospice Care

If Medicare does not cover a service or supply, then it is not a covered service except as provided below.

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.

Maternity and Reproductive Health Services

If Medicare does not cover a service or supply, then it is not a covered service except as provided below.

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

If Medicare does not cover a service or supply, then it is not a covered service except as provided below.

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

If Medicare does not cover a service or supply, then it is not a covered service except as provided below.

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.

Preventive Care

If Medicare does not cover a service or supply, then it is not a covered service except as provided below.

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.

Therapy Services

If Medicare does not cover a service or supply, then it is not a covered service except as provided below.

Physical Medicine Therapy Services

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 only when received from an In-Network Provider and are 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.

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.

Urgent Care Services

If Medicare does not cover a service or supply, then it is not a covered service except as provided below.

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.

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) **Acupuncture/nerve pathway therapy**.

3) **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.

4) **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.

5) **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.

6) **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis and intensive behavior interventions) for all indications.

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

8) **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.

9) **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.

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

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

12) **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.

13) **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.

14) **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.

15) **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.

16) **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.

17) **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).

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

19) **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.

20) **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.

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

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

23) **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**.

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

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

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

58) **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.

59) **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.

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

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

65) **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.

66) **Prescription Drugs.**

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.

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) **Weight Loss Surgery** Bariatric surgery. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgeries lower stomach capacity and divert partly digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgeries that reduce stomach size), or gastric banding procedures.

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

Section 9. Member Payment Responsibility

Your Cost-Shares

Your Plan may involve Deductibles, Copayments, and Coinsurance (as described below). Your Cost Sharing requirements are based on the Medicare allowed amount for services covered by Medicare up to the Maximum Allowed Amount of this Plan. For those services not covered by Medicare but that are covered under this Booklet your Cost Sharing requirements are based on Our Maximum Allowed Amount.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services that are covered by this Booklet, but not covered by Medicare. Reimbursement for services rendered by In-Network and Out-of-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.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, except as explained in this Booklet, when you receive Covered Services from an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

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.

Member Cost Share

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

We will not provide any reimbursement for non-Covered Services or services provided by a Provider who is NOT a contracted Provider. Both services specifically excluded by the terms of this Booklet and those received after benefits have been exhausted are non-Covered Services.

Under certain circumstances, if We, on behalf of the Plan, pay the Provider amounts that are your responsibility, such as Deductibles or Coinsurance, We may collect such amounts directly from you. You agree that We, on behalf of the Plan, have the right to collect such amounts from you.

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 services 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)

For services not covered by Medicare that are covered under this Booklet, when a PPO or Participating Provider bills Us for Covered Services, We will authorize payment from the Plan of the appropriate charges for the benefit directly to the Provider. You are responsible for providing the PPO or Participating Provider with all information necessary for the Provider to submit a claim. You pay the applicable Deductible and/or Coinsurance to the Provider when the Covered Service is received.

If you receive care from an Out-of-Network Provider, you will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file your claim for you, although they are not required to do so. If you file the claim, use a claim form as described later in this section.

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.

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.

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.

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.

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

Except as otherwise provided, your coverage may terminate in the following situations:

- When the Administrative Services Agreement between the Employer and us terminates. It will be the Employer's responsibility to notify you of the termination of coverage.
- Upon the Subscriber's death.
- If you choose to terminate your coverage. We must receive a 31-day advance notice to end coverage. We will credit Fees paid in advance unless we do not receive the cancellation request at least 31-days before the effective date of the cancellation.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, the Employer and/or you must notify us immediately. The Employer and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Employer as an option instead of this Plan, subject to the consent of the Employer. The Employer agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30 calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowable Amount for such services, less any Copayments made or Fees paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Fee, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the fraudulent use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Employer. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.
- When a Dependent no longer qualifies as a Dependent.
- On the date of a final divorce decree or legal separation for dependent spouse.
- When legal custody of a child placed for adoption ends.

You will be notified in writing of the date your coverage ends by either us or the Employer.

Removal of Members

Upon written request through the Employer, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the

termination date even if we have preauthorized the service, unless the Provider confirmed eligibility within two business days before the service is received.

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.

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.

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.

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.

Booklet

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

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.

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.

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.

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.

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.

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.

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.

You will often get a lower level of benefits when you use Out-of-Network Providers.

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.

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.

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.

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.

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.

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.

Subscriber

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

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 ရရိုင်ခွင့် 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
ທ ່ານມ ີສ ິດໄດ ້ຮ ັບຂ ໍ ້ມ ູນ ີ ້ ແລະ
ຄວາມຊ ່ ວຍເຫ ຼ ືອ ປະ ້ ນພາສາຂອງທ ່ ານໂດຍ ບ ໍ ່ ເສ ຍ ຄ ່ າ.
ໂທຫາເບ ີ ໂທຂອງຝ ່ ายບ ໍ ລ ິ ການສະມາຊ ິ ກທ ີ ່ ໃຫ ້ ໄວ ້ ໃນ ບ ັ ດປະຈ ໍ າ ຕ ົ ວຂອງທ ່ ານ
ຫ ລ ື ອ ຂ ໍ ຄວາມຊ ່ ວຍເຫ ຼ ືອ. (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