A Guide to Your Benefits

You've made a good decision in choosing BlueClassic

0KBS-0712

COLGPPONGF CO BlueClassic 20 30-60-3000/2000-80% (01-12)

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

Anthem Blue Cross and Blue Shield
BlueClassic for Group
30-60-3000/2000-80%
15/40/60/30%

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but the patient pays more for Out-of-Network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

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

	IN-NETWORK	**OUT-OF-NETWORK**
4. DEDUCTIBLE TYPE[2]	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE[2a] **a) Individual[2b]** **b) Family[2c]**	 $3,000 $9,000 Some Covered Services have a maximum benefit of days, visits or dollar amounts. When the Deductible is applied to a Covered Service which has a maximum number of days or visits, those maximum benefits will be reduced by the amount applied toward the Deductible, whether or not the Covered Service is paid.	 $6,000 $18,000 Some Covered Services have a maximum benefit of days, visits or dollar amounts allowed. When the Deductible is applied to a Covered Service which has a maximum number of days or visits, those maximum benefits will be reduced by the amount applied toward the Deductible, whether or not the Covered Service is paid.

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

	IN-NETWORK	OUT-OF-NETWORK
5. OUT-OF-POCKET ANNUAL MAXIMUM[3]		
a) Individual	$2,000 excludes Deductible and Copayments	$4,000 excludes Deductible
b) Family	$4,000 excludes Deductible and Copayments	$8,000 excludes Deductible
c) Is deductible included in the out-of-pocket maximum?	No Some Covered Services have a maximum number of days, visits or dollar amounts allowed. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied.	No Some Covered Services have a maximum number of days, visits or dollar amounts allowed. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied. The difference between Billed Charges and the Maximum Allowed Amount for non-participating Providers does not count toward the Out-of-Pocket Annual Maximum. Even once the Out-of-Pocket Annual Maximum is satisfied, you will still be responsible for paying the difference between the Maximum Allowed Amount and the non-participating Providers Billed Charges (sometimes called “balance billing”). The amounts you pay for Out-of-Network Covered Services are in addition to your balance billing costs.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum for most Covered Services. Infertility diagnostic services have a lifetime maximum benefit of $2,000 per Member In and Out-of-Network combined.	No lifetime maximum for most Covered Services. Infertility diagnostic services have a lifetime maximum benefit of $2,000 per Member In and Out-of-Network combined.
7A. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO Provider network. See Provider directory for complete list of current Providers.	All Providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes

	IN-NETWORK	OUT-OF-NETWORK
8. MEDICAL OFFICE VISITS[4]		
a) Primary Care Providers	$30 Copayment per office visit which includes all outpatient laboratory and x-ray services performed. You pay 20% for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services.	You pay 40% after Deductible
b) Specialists	$60 Copayment per office visit which includes all outpatient laboratory and x-ray services performed. You pay 20% for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services.	You pay 40% after Deductible
9. PREVENTIVE CARE		
a) Children's services	No Copayment (100% covered)	$60 Copayment per office visit.
b) Adult's services	No Copayment (100% covered) Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations and office visits; and are not subject to Coinsurance or Deductible.	$60 Copayment per office visit. For covered colonoscopy facility services, you pay $500 Copayment. Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations and office visits; and are not subject to Coinsurance or Deductible.
10. MATERNITY		
a) Prenatal care	$30 Copayment for services from a Primary Care Provider or $60 Copayment for services from a Specialist, for first prenatal care office visit/delivery from the Doctor. Copayment includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services.	You pay 40% after Deductible for prenatal care office visits/delivery from the Doctor
b) Delivery & inpatient well baby care[5]	You pay 20% after Deductible for facility services.	You pay 40% after Deductible for facility services
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions[6]		
a) Inpatient Care	Included with the inpatient Hospital benefit (see line 12).	Included with the inpatient Hospital benefit (see line 12).
b) Outpatient Pharmacy	**Retail Pharmacy Drugs** - Tier 1 $15 Copayment, tier 2 $40 Copayment, tier 3 $60 Copayment, tier 4 30% Copayment, per prescription at a participating pharmacy up to a 30-day	Not covered

	IN-NETWORK	OUT-OF-NETWORK
	supply. For tier 4 Retail Pharmacy Drugs, the maximum Copayment per prescription is $250 per 30-day supply.	
	Specialty Pharmacy Drugs - Tier 1 $15 Copayment, tier 2 $40 Copayment, tier 3 $60 Copayment, tier 4 30% Copayment, per prescription from our Specialty Pharmacy up to a 30-day supply. For tier 4 Specialty Pharmacy Drugs the maximum Copayment per prescription is $250 per 30-day supply from our Specialty Pharmacy. Specialty Pharmacy Drugs are not available at a Retail Pharmacy or from a Home Delivery pharmacy.	Not covered
c) Home Delivery Pharmacy	**Home Delivery Pharmacy Drugs** - Tier 1 $15 Copayment, tier 2 $80 Copayment, tier 3 $120 Copayment, tier 4 30% Copayment, per prescription through the Home Delivery service up to a 90-day supply. For the tier 4 Home Delivery drugs, the maximum Copayment per prescription is $250 per 30-day supply or $500 per 90-day supply. Specialty pharmacy drugs are not available through the Home Delivery service.	Not covered
	The following applies to b) and c) above: Includes coverage for smoking cessation prescription Legend Drugs when enrolled in a smoking cessation counseling program approved by Us. Tier 4 Prescription Drug Copayments will accrue to a maximum Copayment of $3,500 per Member per calendar year. Once you have satisfied the $3,500 maximum Copayment, no additional Copayments will be required for the remainder of the calendar year for tier 4 Prescription Drugs. Prescription Drugs will always be dispensed as ordered by your Provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket costs. You may request, or your Provider may order, the Brand Name Drug. However, if a Generic Drug is available, you will be responsible for the cost difference between the Generic and Brand Name Drug, in addition to your Generic Copayment. The cost difference between the Generic and Brand Name Drug does	Not covered

	IN-NETWORK	OUT-OF-NETWORK
	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. For drugs on our approved list, call member services at 877-811-3106.	
12. INPATIENT HOSPITAL	You pay 20% after Deductible	You pay 40% after Deductible
13. OUTPATIENT / AMBULATORY SURGERY	You pay 20% after Deductible. You pay no Deductible or Coinsurance (100% covered) for laboratory and x-ray services except for MRI, CT, PET scans, nuclear medicine and other high-tech services which are covered at 20% after Deductible.	You pay 40% after Deductible
14. DIAGNOSTICS **a) Laboratory & x-ray**	You pay no Deductible or Coinsurance (100% covered)	You pay 40% after Deductible
b) MRI, nuclear medicine, and other high-tech services	You pay 20% after Deductible	You pay 40% after Deductible
15. EMERGENCY CARE[7,8]	$200 Copayment per visit. Copayment is waived if admitted. You pay no Deductible or Coinsurance (100% covered) for all other services except for MRI, CT, PET scans, nuclear medicine and other high-tech services. For MRI, CT, PET scans, nuclear medicine and other high-tech services you pay 20% after Deductible.	Out-of-Network care is paid as In-Network
16. AMBULANCE	You pay 20% after Deductible	Out-of-Network care is paid as In-Network
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$60 Copayment per visit which includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services.	You pay 40% after Deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.

	IN-NETWORK	OUT-OF-NETWORK
19. OTHER MENTAL HEALTH CARE **a) Inpatient care**	You pay 20% after Deductible	You pay 40% after Deductible
b) Outpatient care	For outpatient facility services, you pay 20% after Deductible; for outpatient office visits and professional services, you pay $30 Copayment per visit. Mental health care includes without limitation, biologically based mental illness, care that has a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition.	You pay 40% after Deductible Mental health care includes without limitation, biologically based mental illness, care that has a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition.
20. ALCOHOL & SUBSTANCE ABUSE **a) Inpatient**	You pay 20% after Deductible	You pay 40% after Deductible
b) Outpatient	For outpatient facility services, you pay 20% after Deductible; for outpatient office visits and professional services, you pay $30 Copayment per visit.	You pay 40% after Deductible
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY **a) Inpatient**	Included with the inpatient Hospital benefit (see line 12). Up to 30 inpatient rehab days per calendar year In and Out-of-Network combined.	Included with the inpatient Hospital benefit (see line 12). Up to 30 inpatient rehab days per calendar year In and Out-of-Network combined.
b) Outpatient	You pay 20% after Deductible. Up to 20 visits each for physical, occupational and speech therapy per calendar year In and Out-of-Network combined. From birth until the Member's sixth birthday, benefits are provided as required by applicable law.	You pay 40% after Deductible**.** Up to 20 visits each for physical, occupational and speech therapy per calendar year In and Out-of-Network combined. From birth until the Member's sixth birthday benefits are provided as required by applicable law.
22. DURABLE MEDICAL EQUIPMENT	You pay 20% after Deductible	Not covered
23. OXYGEN	You pay 20% after Deductible	Not covered

	IN-NETWORK	OUT-OF-NETWORK
24. ORGAN TRANSPLANTS **a) Inpatient**	You pay 20% after Deductible	Not covered
b) Outpatient	$30 Copayment per office visit for services from a Primary Care Provider or $60 Copayment per office visit for services from a Specialist. Copayment includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services. Transportation and lodging services are limited to a maximum benefit of $10,000; unrelated donor searches are limited to a maximum benefit of $30,000.	Not covered
25. HOME HEALTH CARE	You pay 20% after Deductible. Up to 100 visits per calendar year.	Not covered
26. HOSPICE CARE **a) Inpatient**	You pay no Deductible or Coinsurance	You pay 40% after Deductible
b) Outpatient	You pay no Deductible or Coinsurance	You pay 40% after Deductible
27. SKILLED NURSING FACILITY CARE	You pay 20% after Deductible. Up to 100 days per calendar year In and Out-of-Network combined.	You pay 40% after Deductible. Up to 100 days per calendar year In and Out-of-Network combined.
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Not covered	Not covered
30. CHIROPRACTIC CARE	$30 Copayment per office visit which includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services. Up to 20 visits per calendar year combined with massage therapy and acupuncture care.	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	**Retail Health Clinic** $30 Copayment per office visit which includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services. **Other Covered Services** • **Massage Therapy / Acupuncture**	Not covered

	IN-NETWORK	OUT-OF-NETWORK
	Care - $30 Copayment per office visit which includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services. Up to 20 visits per calendar year combined with chiropractic care.	Not covered
	• **Nutritional Therapy -** $30 Copayment per visit for Specialist. Up to 4 visits per calendar year.	Not covered
	Hearing Aids Benefit level determined by place of service. Hearing aids are covered up to age 18 and are supplied every 5 years, except as required by law.	**Hearing Aids** Benefit level determined by place of service. Hearing aids are covered up to age 18 and are supplied every 5 years, except as required by law.
	T**reatment of Autism Spectrum Disorders** Benefit level determined by type of service provided.	T**reatment of Autism Spectrum Disorders** Benefit level determined by type of service provided.
	The following annual maximums, based on calendar year, are effective for applied behavior analysis services for In and Out-of-Network services combined:	The following annual maximums, based on calendar year, are effective for applied behavior analysis services for In and Out-of-Network services combined:
	• From birth to age eight (up to Member's ninth birthday): $34,000 In and Out-of-Network combined	• From birth to age eight (up to Member's ninth birthday): $34,000 In and Out-of-Network combined
	• Age nine to age eighteen (up to Member's nineteenth birthday): $12,000 In and Out-of-Network combined	• Age nine to age eighteen (up to Member's nineteenth birthday): $12,000 In and Out-of-Network combined
	General Information For any outpatient Covered Service not elsewhere listed, you pay Coinsurance after Deductible. For example, this includes chemotherapy and outpatient non-surgical facility services.	**General Information** For any outpatient Covered Service not elsewhere listed, you pay Coinsurance after Deductible. For example, this includes chemotherapy and outpatient non-surgical facility services.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. [10]	6 months for all pre-existing conditions.

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

PART D: USING THE PLAN

	IN-NETWORK	**OUT-OF-NETWORK**
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the Doctor who schedules the procedure or Hospital care is responsible for obtaining Preauthorization.	Yes, the Member is responsible for obtaining Preauthorization unless the Provider participates with Anthem Blue Cross and Blue Shield.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, you will be responsible for paying the difference between the Maximum Allowed Amount and the non-participating Provider's Billed Charges (sometimes called "balance billing"). The amounts you pay for Out-of-Network Covered Services are in addition to your balance billing costs.
39. What is the main customer service number?	877-811-3106	877-811-3106
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273 877-811-3106	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273 877-811-3106
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form #'s COLGPPONGF Group – Large	Policy form #'s COLGPPONGF Group – Large
43. Does the plan have a binding arbitration clause?	Yes	Yes

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

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

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

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

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

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

[4] Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

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

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

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

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

[9] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

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

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

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

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

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

All services are subject to medial necessity. Medical necessity means an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that Anthem or HMO Colorado, subject to a Member's right to appeal, solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a 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, it also means that safe and adequate care could not be obtained as an outpatient;
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost);
- Not Experimental or Investigational;
- Not primarily for you, your family's or the Provider convenience; and
- Not otherwise subject to an exclusion under the 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.

<u>For those enrolled on a health benefit plan other than the Colorado Basic Limited Mandate Health Benefit Plan:</u>

Small employers purchasing any health benefit plan other than the Colorado Basic Limited Mandate Health Benefit Plan must pay for all of the mandated benefits pursuant to section 10-16-104, C.R.S. The premium for this plan includes the cost of these mandated benefits, specifically: coverages for newborn, maternity, pregnancy, childbirth, and complications from pregnancy and childbirth; therapies for congenital defects and birth abnormalities; mental illness; biologically-based mental illness; the availability of alcoholism treatment; the availability of hospice care; prostate cancer screening; child health supervision; hospitalization and general anesthesia for dental procedures for dependent children; diabetes; prosthetic devices; early intervention services for certain children; assessment, diagnosis and treatment of autism spectrum disorders for children under nineteen; colorectal screening; cervical cancer vaccinations; certain preventive health services; hearing aids for minors; and certain routine care during participation in a clinical trial.

<u>For those enrolled on the Colorado Basic Limited Mandate Health Benefit Plan:</u>

Interested policyholders, certificate holders, and enrollees are hereby given notice that this small group policy does not cover all the health services and benefits, including prostate screenings, mental health, alcoholism, and dental anesthesia for children, which the Colorado Revised Statutes usually require group plans to cover.

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

1. **Non-payment of the required premium;**
2. **Fraud or intentional misrepresentation of material fact on the part of the plan sponsor;**
3. **The policyholder fails to comply with participation or contribution rules;**
4. **The carrier elects to discontinue offering and non-renew all of its small group or large group plans delivered or issued for delivery in Colorado;**

5. **An employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan;**
6. **With respect to group health benefit plans offered through a managed care plan, there are no longer any enrollees who live, reside or work in the Service Area; or**
7. **With respect to coverage of an employer that is made available only through one or more bona fide associations, the membership of an employer ceases.**

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

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

Cancer Screenings

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

Pap Tests

All plans provide coverage under the preventive care benefits for a routine annual Pap test and the related office visit. Payment for the routine Pap test is based on the plan's provisions for preventive care service. Payment for the related office visit is based on the plan's preventive care provisions.

Mammogram Screenings

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

Prostate Cancer Screenings

All plans except our HMO and PPO Basic Health Plans provide coverage under the preventive care benefits for routine prostate cancer screening for men. Payment for the prostate cancer screening is based on the plan's provisions for preventive care.

Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All plans provide coverage for routine colorectal cancer screenings, such as fecal occult blood tests, barium enema, sigmoidscopies and colonoscopies. Depending on the type of colorectal cancer screening received, payment for the benefit is based on where the services are rendered and if rendered as a screening or medical procedure. Colorectal cancer screenings are covered under preventive care as long as the services provided are for a preventive screening. Payment for preventive colorectal cancer screenings based on the plan's provisions for preventive care.

The information above is only a summary of the benefits described. The Booklet for each health plan includes important additional information about limitations, exclusions and covered benefits. The Colorado Health Benefit Plan Description Form for each health plan includes additional information about Copayments, Deductibles and Coinsurance. If you have any questions, please call our member services department at the phone number on the Colorado Health Benefit Plan Description Form.

SUMMARY OF THE LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Introduction

Residents of Colorado who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Life and Health Insurance Protection Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Colorado and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

IMPORTANT DISCLAIMER

The Life and Health Insurance Protection Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require residency in Colorado. You should not rely on coverage by the Life and Health Insurance Protection Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the association to induce you to purchase any kind of insurance policy.

Summary

The state law that provides for this safety-net coverage is called the Life and Health Insurance Protection Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association.

Coverage

Generally, individuals will be protected by the Life and Health Insurance Protection Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Certain parties to structured settlement annuity contracts may be entitled to coverage benefits as well based on defined circumstances.

This Information is Provided By:	
Life & Health Insurance Protection Association P.O. Box 36009 Denver, CO 80236 (303) 292-5022	Colorado Division of Insurance 1560 Broadway Suite 850 Denver, CO 80202 (303) 894-7499

Exclusions From Coverage

Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Colorado, except under certain very specific circumstances
- the insurer was not authorized or licensed to do business in Colorado at the time the policy or contract was issued;

- their policy was issued by a nonprofit hospital or health service corporation, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rate yields, crediting rate yields or other factors employed in calculating returns, including but not limited to indexes or other external references stated in the policy or contract, that exceed an average rate specified in the Association Act;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- any unallocated annuity;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- policies or contracts issued by an insurer which was insolvent or unable to fulfill its contractual obligations as of July 1, 1991, except for annuity contracts issued by a member insurer which was placed into liquidation between July 1, 1991, and August 31, 1991;
- policies or contracts covering persons who are not citizens of the United States;
- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

Limits On Amount Of Coverage

The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the Association will pay a maximum of:

- $300,000 in net life insurance death benefits and no more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits - $100,000 for coverages not defined as disability, basic hospital, medical and surgical, or major medical insurance, including any net cash surrender and net cash withdrawal values; $300,000 for disability insurance; or $500,000 for basic hospital, medical and surgical, or major medical insurance;
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or
- with respect to each payee of a structured settlement annuity, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- $300,000 for long term care benefits.

The Association shall not be liable to expend more than $300,000 in the aggregate, with respect to any one life except that with respect to benefits for basic hospital, medical and surgical and major medical insurance, the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual.

TITLE PAGE (COVER PAGE)

Anthem Blue Cross and Blue Shield
BlueClassic for Group
30-60-3000/2000-80%
15/40/60/30%

CONTACT US

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

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

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

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

Mike Ramseier
President and General Manager
Anthem Blue Cross and Blue Shield

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

Health benefit coverage is defined in the following documents:

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

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

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

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

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

Your Rigths and Responsibilities as an

Anthem Blue Cross Blue Shield Member

As an Anthem Blue Cross Blue Shield Member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your Doctors. It's kind of like a "Bill of Rights". And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your Doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and Federal laws, and our privacy rules.
- Get information about our company and services, and our network of Doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
  - Your health care plan
  - Any care you get
  - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your Doctor tell you how that may affect your health now and in the future.
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a Doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your Doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your Doctors or health care professionals.
- Tell your Doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.

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

For details about your coverage and benefits, please read your Booklet.

How to Obtain Language Assistance

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

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ELIGIBILITY

Subscriber

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

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

Dependents

Your Dependents may include the following:

- **Legal spouse**.
- **Common-law spouse**. A "Common-Law Marriage Affidavit" is needed to enroll a common-law spouse. You can get the affidavit from your employer or you can call Us. All references to spouse in this Booklet include a common-law spouse.

  A common law spouse is an eligible Dependent who has a valid common-law marriage in Colorado. This is the same as any other marriage and can only end by death or divorce.
- **Designated beneficiary**. Your employer may have decided to offer benefits under this plan to designated beneficiaries. Check with your employer to learn more. If they are recognized by the employer, all references to spouse in this Booklet include a designated beneficiary. A designated beneficiary is not eligible for COBRA under this Booklet.
- **Same-sex and opposite-sex domestic partner**. You must send Us a "Certificate of Domestic Partnership" for a domestic partner to be eligible. You can get this certificate from your employer or you can call Us. Check with your employer to see if they will be eligible. If domestic partners are recognized by the employer, all references to spouse in this Booklet include a domestic partner.
- **Newborn child**. A newborn child born to you or your spouse is covered under your coverage for the first 31 days of birth. If the newborn is your grandchild, the newborn is usually **not** covered (see the "Grandchild" heading in this section).

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

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

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

  To keep the adopted child's coverage beyond the 31-day, you must send Us an "Enrollment Application and Change Form" to add the adopted child. We must get this form within 31 days after the placement of the child for adoption to continue coverage for the 32nd day and thereafter.
- **Dependent child**. A child (including a stepchild or a disabled child) under 26 years of age may be covered under the terms of this Booklet. Coverage stops at the end of the month in which the child turns 26. If you or your spouse have a qualified medical child support order for this child, the Dependent child is eligible for coverage, up to age 26, whether the child lives with you or your spouse.
- **Disabled Dependent child**. An unmarried child who is 26 years or older, medically certified as disabled, and dependent on the parent may be covered under the terms of this Booklet. We must receive notice of the disability for the disabled Dependent coverage to continue after the Dependent child turns age 26. You and the disabled Dependent's Doctor must send Us a "Mentally or Physically Disabled Dependent Form". You may call Us or visit Our website to get such form.

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

Medicare-Eligible Members

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

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

Enrollment Process

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

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

Enrollment Forms

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

Initial Enrollment

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

Open Enrollment

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

Newly Eligible Dependent Enrollment

You may add a Dependent who becomes newly eligible due to a qualifying event. Qualifying events include marriage, birth, placement for adoption or issuance of a court order. To add the Dependent, We must get an "Enrollment Application and Change Form" within 31 days of the date of the event. Proof of the event, e.g., a copy of the marriage certificate or court order, must be attached to the form. Coverage will be effective on the date of the qualifying event.

When you or your spouse are required by a court or administrative order to cover an eligible Dependent for child support, the eligible Dependent must be enrolled within 31 days of the issuance of such order. We must receive a copy of the court or administrative order with the "Enrollment Application and Change Form". If you do not add the eligible Dependent within 31 days of the issuance of the order, you must wait until the next open enrollment to add the Dependent.

Special Enrollment for Eligible Employees and Eligible Dependents

Special enrollment is available for those who are not enrolled in the employer health coverage with Us. This is allowed when there is a change in family status or when there is an involuntary loss of group coverage.

Family Status Change - Qualifying events for special enrollment due to a family status change are marriage, divorce, birth, placement for adoption or a qualified medical child support order. If the employer has elected to cover designated beneficiaries, a family status change includes the addition of a designated beneficiary. We must get the "Enrollment Application and Change Form" within 31 days after the date of the event. Proof of such event must be with the form. Examples of proof may be a copy of the marriage certificate or court order. If you get the form to Us on time, coverage with Us starts on the date of the qualifying event. When the event is a birth, labor and delivery benefits are not covered if the mother is not on the plan.

Involuntary Loss of Other Group Coverage – An involuntary loss of other coverage is when the other group coverage stops due to a loss of employment, the reduction of work hours, or other involuntary loss of Creditable Coverage. It can also be due to the death of an employee, legal separation or divorce, or loss of Dependent or designated beneficiary status under the other plan. It can also happen when the other plan no longer covers a class of individuals, or the

employer no longer helps pay for the coverage, or when all benefits end because the person no longer lives, resides or works in the service area of the plan.

If you are approved for special enrollment, coverage with Us starts on the day after the loss of other coverage. If the other plan offers continuation of coverage, you can only ask for coverage with Us after that coverage ends (or you can enroll at the next open enrollment).

The loss of other coverage must be involuntary. If you decide to end the other coverage, you do not qualify for special enrollment. But, you can enroll at the next open enrollment.

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

Late Entrants

To be added as a late entrant (including voluntary loss of coverage), you may only apply during the employer's open enrollment period. If approved, coverage will start on the employer's Anniversary Date. A six-month exclusion for pre-existing condition will apply for late entrants. Please see pre-existing conditions in "Limitations/Exclusions (What Is Not Covered and Pre-Existing Conditions)" for details.

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

- At the initial enrollment period;
- At open enrollment;
- As a newly eligible person; or
- After a qualifying event for special enrollment.

If you enroll as a late entrant, your eligible Dependents applying at the same time will also be late entrants.

Military Service

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

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

  When coverage is reinstated, We won't impose an exclusion or waiting period, except if it would have applied had coverage not been terminated because of service. But, we may impose an exclusion or waiting period for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

Multiple Coverage Plans with Us

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

How to Change Coverage

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

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

This is a Preferred Provider Organization (PPO) plan, which means you have In-Network (participating) and Out-of-Network (non-participating) benefits.

This PPO coverage lets you choose how to use your benefits and control your out-of-pocket costs. When you get care from In-Network Providers, you receive the highest level of benefits at the lowest cost. The *Schedule of Benefits* lists payment levels for both In-Network and Out-of-Network care. We publish a directory of participating Providers. You can get a directory from your employer or from Us. You may call the Member services number that is listed on your Health Benefit ID Card or you may write Us and ask that we send you a directory. You may also search for a Provider on-line at www.anthem.com.

Providers

Participating Providers (In-Network)

Participating Providers have a network agreement with Us for this health benefit plan. Covered Services provided by a participating Provider are considered In-Network. When you see a participating Provider you have lower out-of-pocket costs. Your In-Network Cost Sharing for participating Providers is on the *Schedule of Benefits* under the heading of "In Network". You need to check to see if your Provider is a participating Provider before your visit. To do that, you can check Our website or call Our Member services.

We do not guarantee that a participating Provider is available for all services and supplies covered under your PPO coverage. For some services and supplies, We may not have arrangements with participating Providers. Please call Our Member services for a list of the counties where We may not have participating Providers for such services and supplies.

Sometimes you may need to travel a reasonable distance to get care from a participating Provider. This does not apply if care is for an Emergency. If you choose to obtain the service from a non-participating Provider rather than the participating Provider, you will need to pay for any charges from the non-participating Provider that are over Our Maximum Allowed Amount. The Maximum Allowed Amount is the most we will allow for a Covered Service

If We don't have a participating Provider within a reasonable number of miles from your home for a Covered Service, you may be able to obtain a preauthorized network exception to obtain care from a non-participating Provider at the In-Network benefit level. If you want to get a network exception to receive coverage for a Covered Service from a non-participating Provider at the In-Network level of benefits, you must call the Member services to request this exception before getting the Covered Service from a non-participating Provider. If approved, We will pay the non-participating Provider at the In-Network level of benefits and you won't need to pay more for the services than if the services had been received from a participating Provider.

If you do not receive a preauthorized network exception to obtain Covered Services from a non-participating Provider, the claim will be processed using your Out-of-Network cost shares.

Non-participating Providers (Out-of-Network)

Providers who have not signed a PPO Provider contract with Us are non-participating Providers under this PPO plan. Services provided by a non-participating Provider are considered Out-of-Network. When you see a non-participating Provider you may have higher Out-of-Pocket costs. Your Out-of-Network Cost Sharing responsibilities for non-participating Providers may be found on the *Schedule of Benefits* under the "Out-of-Network" heading.

We will not deny or restrict Covered Services just because you get treatment from a non-participating Provider; however, you may have to pay more. The Cost Sharing for Covered Services from a non-participating Provider may be larger. Also, non-participating Providers do not have to accept our Maximum Allowed Amount as full payment. They can charge or "balance bill" you for any amount of their bill which We do not pay. This "balance billing" cost is on top of, and does not count toward, your Cost Sharing obligation.

We pay the benefits of this Booklet directly to non-participating Providers, if you have authorized an assignment of benefits. An assignment of benefits means you want Us to pay the Provider instead of you. We may require a copy of the assignment of benefits for Our records. These payments fulfill our obligation to you for those services.

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for purchase by your employer group. If your group has selected this option, You may receive incentives such as gift cards by taking part in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. (Use of gift cards for purposes other than for qualified medical costs may result in taxable income to you. For additional guidance, please consult your tax advisor.) These programs are not Covered Services under Your group health plan but are a value added

pieces to your plan benefits. These program features are not guaranteed under your Booklet and could be ended at any time.

Managed Care Features

Managed care is Our way of giving you access to quality, cost effective health care. It uses tools like utilization management and cost of services, and measures Provider and coverage performance. We use a variety of administrative processes and tools, such as Preauthorization for health care services, Care Management, concurrent Hospital review and disease management to help decide the right use of the health care services available to Our Members. This section of the Booklet explains how these managed care features are used and will guide you through the steps to get care. For more information on what to do for Emergency care and Urgent Care, please see the "Benefits/Coverage (What Is Covered)" section.

You are free to choose your Hospital and attending Doctors. But not all Providers are covered under this Booklet. We require that Doctors hold a valid Doctor's license, practice within the scope of that license and be a member of, or acceptable to, the attending staff and board of directors of the Hospital in which the services are to be provided.

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

Our Process to Determine if Services are Covered

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

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

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

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

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

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

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

Appropriate Place and Preauthorization

You can get care in an inpatient or outpatient setting. The setting depends on your health condition and what services are needed to manage your health. We cover care in both places if the care received is a Covered Service and is appropriate to the setting and is Medically Necessary. Examples of inpatient settings include Hospitals, Skilled Nursing Facilities and Hospice Facilities. Examples of Outpatient setting are the Doctors' office, ambulatory Surgery center, Retail Health Clinic, Home Care and home Hospice settings. For human organ transplant services to be covered they need to be received

from a Center of Excellence To determine which Covered Services must be received from a designated facility or Center of Excellence contact Member services. Covered Services received from a non-designated facility may be denied or paid at a lower amount.

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

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

If you are using a non-participating Provider or an out-of-state participating Provider, you need to make sure that the Provider asks for and gets the Preauthorization from Us. If you don't get the Preauthorization you may have to pay for any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact Us.

Inpatient Admissions - Inpatient admissions include admissions to acute care Facility Providers (Hospitals), long-term care Facility Providers, sub-acute Facility Providers, rehab Facility Providers, Skilled Nursing Care Facility Providers and inpatient Hospice Facility Providers. Admissions for all inpatient stays require Preauthorization. Also, once admitted, further care will be reviewed under Our concurrent review guidelines. Your Provider must call the number for Provider authorization on your Health Benefit ID Card to request Preauthorization. We will review the request for Preauthorization. If the inpatient stay is approved, all benefits available under your coverage are provided for the set number of days We have preauthorized If additional days are requested by the Provider, we will reevaluate Our Preauthorization. This helps with your timely discharge or transfer to the appropriate level of care.

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

Scheduled Admissions - Your Provider should get Preauthorization from Us at least 15 days before a planned admission begins. Then, if the stay goes over the number of days on the Preauthorization, the Provider must get additional authorization. We will send written confirmation of Our decision to you and your Provider within two business days of receipt of all necessary information.

Unscheduled (Emergency) Admissions - You don't need Preauthorization for an Emergency admission. But We do need to be contacted within seventy-two hours after the admission, unless you are unable to do so. If you can't notify Us within seventy-two hours, you still need to notify Us of the admission as soon as you can. We may deny your coverage if you do not tell Us within seventy-two hours. Some examples of Emergency admissions are admissions involving accidents, alcohol detoxification, or the onset of labor in pregnancy.

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

Appropriate Length of Stay

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

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

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

When We Need More Information

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

If a Preauthorization of a requested service meets Medical Necessity criteria, it **does not guarantee** that payment will be allowed. Fraud or abuse, or changes in eligibility afterwards, could cause a denial of payment. When We receive your claim(s), We will review them against the terms of this Booklet. Also, the Preauthorization is only good for a specific place and period of time. Services which are not given in the place and time authorized may be denied. If additional services or time are needed, another or extended Preauthorization is required.

When We Deny Preauthorization

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

Retrospective Claim Review

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

Ongoing Care Needs

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

Transition of Care

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

Utilization Management

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

Care Management

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

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

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

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

Disease Management

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

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

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

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

We have an agreement with Providers who participate in disease management programs. The agreement may include financial incentives or risk-sharing relationships. These relationships are related to the services provided or to referrals to other Providers. These other Providers include network Providers and disease management programs. You can contact your Provider or us if you have questions about these incentives and risk-sharing relationships.

Participation in Ongoing Needs Programs

There are several ways for you to become involved in one of Our care management or disease management programs. We can identify Members that We believe may benefit from the programs, or Doctors may refer their patients to Us. You may also call Us directly at Our "Help Line" (303) 764-7066 or (877) 225-2583. Additional information about Our disease management and wellness programs is available on Our website under the "Blue*Cares* for You" heading.

BENEFITS/COVERAGE (What is Covered)

This section describes your benefits. You must get care from a participating Provider for your benefits to be covered at the In-Network level. The exceptions to this are Emergency Care, Urgent Care or when preauthorized by Us. Services which are not received from a participating Provider may be covered Out-of-Network. Not all Covered Services are covered Out-of-Network. To learn more, read your *Schedule of Benefits*.

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

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

Preventive Care Services

Preventive Care services include Outpatient services and Doctor office services. Preventive Care includes the screenings and services listed below, when no sign or history of a health problem exists.

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

Preventive Care Services are covered as needed by the rules under federal and state laws. Those laws, and so your coverage, may change from time to time. These services fall under four broad types as shown below:

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

  - Breast cancer;

  - Cervical cancer;

  - Colorectal cancer;

  - High blood pressure;

  - Type 2 diabetes Mellitus;

  - Cholesterol; and

  - Child and adult obesity.

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

- Preventive care and screenings for children, adolescents, and adults are based on the comprehensive guidelines from the Health Resources and Services Administration. This includes child health supervision services (including limited services to stop smoking for covered children up to age 13, but only when required by applicable health insurance law.

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

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

http://www.healthcare.gov/center/regulations/prevention.html; **or**

http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/

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

- Routine screening mammogram;

- Routine cytologic screening (pap test);

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

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

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

Infertility Diagnostic Services

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

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

Maternity Services and Newborn Care

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

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

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

- Parent training;
- Physical assessments;
- Assessment of the home support system;
- Help and training in breast or bottle feeding; and
- Performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for the mother or newborn child, including collecting samples for hereditary disease and metabolic newborn screening.

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

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

Diabetes Management Services

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

Diabetes medical nutrition therapy services are not subject and do not lower the nutritional therapy limit as listed on the *Schedule of Benefits*.

Doctor Office Services

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

Office visits may include giving of shots. But if a covered shot is for a Specialty Pharmacy Drug on Our Medical Provider Administered Specialty Drug List, then that drug needs to come from Our Specialty Pharmacy. Otherwise, the shot will not be covered in the Doctors office. Also, if a shot does not need to be given by a Provider in an office visit, the shot is not covered under this Doctor Office Services section. Instead, such a shot will be covered, if at all, under the "Retail Pharmacy/Home Delivery Pharmacy Prescription Drugs" section. More information on Specialty Pharmacy and Specialty Pharmacy Drugs is in this "Benefits/Coverage (What Is Covered)" section.

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

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

Telemedicine Services

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

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

Non-Covered Services are:

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

Inpatient Services

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

Room, Board and General Nursing Services

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

Ancillary Services

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

Other Services

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

Inpatient Rehab Services

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

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

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

Skilled Nursing Care Facility (SNF)

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

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

Outpatient Services

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

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

Outpatient Services may include giving of injections. But if a covered shot is for a Specialty Pharmacy Drug on Our Medical Provider Administered Specialty Drug List, then that drug needs to come from Our Specialty Pharmacy. Otherwise, the shot will not be covered in an outpatient setting. More information on Specialty Pharmacy and Specialty Pharmacy Drugs is in this “Benefits/Coverage (What Is Covered)” section.

Diagnostic Services

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

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

Surgical Services

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

- Surgery or other types of operative services;
- Treating broken bones and dislocations;
- Sterilization services;
- Anesthesia and for an assistant surgeon, but only if allowed by our medical policy. We do not pay for all surgical assistant procedures;
- Normal and related care, before and after Surgery; and
- Other types of services as approved by Us.

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

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

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

Emergency Care and Urgent Care

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

Emergency Care

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

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

Urgent Care

Sometimes the type of you care you need is Urgent and it not an Emergency. Urgent Care can be received from an In-Network Provider or an Out-of-Network Provider. If you visit and Out-of-Network Provider your Cost Shares will be higher. If you have an Accidental Injury or a medical problem, We will decide whether your injury or medical problem is Urgent Care or Emergency Care for coverage purposes, based on your diagnosis and symptoms.

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

Obtaining Emergency or Urgent Care

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

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

Ambulance and Transportation Services

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

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

Ground Ambulance is most often Our approved method of transportation. Air Ambulance is only a benefit when it is needed because of terrain, distance or your health problem. We will decide whether transport by air Ambulance is a benefit on a case-by-case basis. If we decide that air Ambulance was used when ground Ambulance could have been used, your coverage will be limited to ground Ambulance benefits.

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

- When ordered by an employer, school, fire or public safety officer and you are not in a position to say no; or
- When We ask you to move from an Out-of-Network Provider to an In-Network Provider.

Trips must be to the closest local Hospital that can give you the Covered Services needed for your health problem. If a local Hospital is not available, you are covered for trips to the closest such Hospital outside your local area.

If you decide not to get transported to a Hospital after an Ambulance has been called, your Copayment, Deductible and/or Coinsurance will still apply. For Emergency Ambulance services from by an Out-of-Network Provider you do not need to pay more than would have been paid for services from an In-Network Provider.

Therapy Services

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

Physical, Speech, and Occupational Therapy

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

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

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

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

Other Therapy Services

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

- within the scope of chiropractic care that supports or is needed to help you reach the physical state enjoyed before the health problem; and
- the services are usually given to diagnose or treat a neuromusculoskeletal health problem linked to an injury or illness.

Coverage is provided for examinations, office visits with manual adjustment of the spine, x-ray of the spine and conjunctive physiotherapy. Benefits are up to the number of visits as listed on the *Schedule of Benefits*;

- **Massage therapy** for injury or illness for which massage has a therapeutic result. Coverage is provided for up to a 60 minute session per visit. Some Covered Services include acupressure and deep tissue massage, or other approved services. Benefits are up to the number of visits as listed on the *Schedule of Benefits*;
- **Acupuncture** is the treatment of a health problem by inserting special needles along specific nerve pathways for healing reasons. Services from an acupuncturist who acts within the scope of their license for the healing process of neuromusculoskeletal pain resulting from an injury or illness. Benefits are up to the number of visits as listed on the *Schedule of Benefits*;
- **Cardiac Rehab** to repair an individual's functional status after a cardiac event. Benefits are allowed at a facility for exercise and education under the direct supervision of a professional Provider in an intensive outpatient rehab program. From 6 to 36 visits per event are allowed based on Our medical policy;
- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents. Chemotherapy services can be given at the Providers office. Chemotherapy medications used along with outpatient therapy may be considered Specialty Pharmacy Drugs when such medication is listed on Our Medical Provider Administered Specialty Drug List and they must be received from Our Specialty Pharmacy. See this ""Benefits/Coverage (What Is Covered)" section for more information;
- **Dialysis** treatments for a short term or chronic kidney illness which may include the use of an artificial kidney machine;
- **Radiation therapy** for the treatment of disease by x-ray, radium or radioactive isotopes; and
- **Inhalation therapy** for the treatment of a health problem by the using medicines, water vapors, gases, or anesthetics by inhalation.

Autism Spectrum Disorders

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

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

Treatment for Autism Spectrum Disorders must be prescribed or ordered by a Doctor or psychologist, and services must be provided by a Provider covered under this plan and approved to provide those services. However, behavior training, behavior management, or Applied Behavior Analysis services (whether provided directly or as part of Therapeutic Care), must be provided by an Autism Services Provider. Coverage of Autism Spectrum Disorders in this "Benefits/Coverage

(What Is Covered)" section is in addition to coverage provided for early intervention and Congenital Defects and Birth Abnormality. Autism services and the Autism Treatment Plan are subject to Utilization Review.

Home Care/Home IV Therapy Services

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

- Professional nursing services you get from a registered nurse (R.N.) or a licensed practical nurse (L.P.N);
- Health care/social services;
- Diagnostic services;
- Nutritional guidance;
- Certified nurse aide services under the supervision of an R.N. or a therapist skilled in professional nursing services;
- Therapy Services like physical, occupational, respiratory, inhalation, speech and hearing therapy. Therapy services are not subject to the therapy limits listed under the *Schedule of Benefits* when provided by a Home Health Agency;
- Social work practice services from a social worker;
- Medical and surgical supplies;
- Durable medical equipment;
- Prescription Drugs but only if provided and billed by a Home Health Care Agency; and
- Specialty Pharmacy Drugs listed on Our Medical Provider Administered Specialty Drug List. These drugs need to be obtained from a Specialty Pharmacy. See this "Benefits/Coverage (What Is Covered)" section for more information.

Home IV Therapy

Home IV therapy is covered and includes a mixture of nursing care, durable medical equipment and IV pharmaceutical services. These are delivered and/or given intravenously in the home. Home IV therapy includes services and supplies such as for Total Parenteral Nutrition (TPN), antibiotic therapy, pain management and chemotherapy. TPN received in the home is a covered benefit for the first 21 days after a Hospital discharge when it is Medically Necessary. More days may be given up to a maximum of 42 days per Benefit Period when preauthorized by Us. Aside from the limits above, home IV therapy services are not subject to the home health care limits listed on the *Schedule of Benefits*.

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

Nutritional Counseling

Nutritional counseling is a way of looking at your food habits and choices with a food expert who offers diet changes and food ideas right for you. The goal of nutrition counseling is to make the right food choices, and improve the nutritional value and dietary supplements in your diet. Benefits are given for a registered dietitian who is a health worker who knows about diet and foods and who is able to translate that information into the right food choices. Registered dietitians must limit their practice to those methods which conform with state and federal laws. We cover up to a 60 minute session for each visit listed on the *Schedule of Benefits*.

Benefits include:

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

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

Medical Foods

Benefits are given for medical foods for home use for metabolic disorders which may be taken by mouth or enterally. A Provider must have prescribed the medical foods that are designed and manufactured for inherited enzymatic disorders involved in the metabolism of amino, organic, and fatty acids. Such disorders include:

- Phenylketonuria, if you are 21 or younger (35 or younger for women of child-bearing age);
- Maternal phenylketonuria;
- Maple syrup urine disease;
- Tyrosinemia;
- Homocystinuria;
- Histidinemia;
- Urea cycle disorders;
- Hyperlysinemia;
- Glutaric acidemias;
- Methylmalonic academia; and
- Propionic acidemia.

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

Hospice Care

Hospice Care may be given in the home or Hospice Facility for a course of treatment for medical, social, psychosocial, and spiritual services used as relief for pain for patients with a terminal illness. Hospice Care includes routine home care, constant home care, inpatient hospice and inpatient respite. To be eligible for hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending Doctor.

Covered Services include Hospice Care when actively managed by a Hospice Facility. The Hospice Facility has to coordinate all Hospice Care, whether you get them at home or at the hospice. 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.

Hospice Care includes:

- Inpatient Hospice Care;
- Hospice day care;
- Home Care services;
- Skilled nursing services (by an R.N. or L.P.N.);
- Certified nurse aide services or nursing services tasked to other caregivers. This must follow state laws that cover such care;
- Social/counseling services;
- Doctor services;
- Physical, occupational, speech and respiratory therapies;
- Nutritional counseling by a nutritionist or dietitian;
- Medical supplies (including respiratory supplies), durable medical equipment (rental or purchase), oxygen, appliances, prostheses and Orthopedic Appliances;
- Counseling services for the covered Member;

- Bereavement support services for the covered family Members;
- Inpatient hospice respite care. Inpatient hospice respite care may be provided only on an intermittent, nonroutine, short-term basis;
- Intravenous medications and other Prescription Drugs ordinarily not available through a Retail Pharmacy;
- Short-term inpatient (acute) Hospice Care or continuous home care which may be required during a period of crisis, for pain control or symptom management;
- Diagnostic testing; and
- Transportation.

Human Organ and Tissue Transplant Services

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

Covered Transplant Procedure

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

Covered transplant procedures include:

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

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

Immunosuppressant drugs prescribed for outpatient used with a covered human organ and tissue transplant that are given only by written prescription and that are approved for general use by the Food and Drug Administration, but only if your coverage has a Prescription Drug benefit.

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

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

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

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

In-Network Transplant Provider

A Provider that has been designated as a "Center of Excellence" by Us and/or a Provider selected to participate as an In-Network transplant Provider by a designee. Such Provider has entered into a transplant Provider agreement to render covered transplant procedures and certain administrative functions to you for the transplant network. A Provider may be an In-Network transplant Provider with respect to:

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

Transplant Benefit Period

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

Prior Approval and Preauthorization

In order to maximize your benefits, We strongly encourage you to call Our transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before you have an evaluation and/or work-up for a transplant. We will assist you in maximizing your benefits by providing coverage information, including details on what is covered and whether any clinical coverage guidelines, medical policies, In-Network transplant Provider requirements, or exclusions are applicable. Contact the Member services telephone number on the back of your Health Benefit ID Card and ask for the transplant coordinator. Even if We issue a prior approval for the covered transplant procedure, you or your Provider must call our transplant department for Preauthorization prior to the transplant whether this is performed in an inpatient or outpatient setting.

Preauthorization is required before We will cover benefits for a transplant. Your Doctor must certify, and We must agree, that the transplant is Medically Necessary. Your Doctor should submit a written request for Preauthorization to Ws as soon as possible to start this process. Failure to obtain Preauthorization will result in a denial of benefits.

Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest and storage is not an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

We will provide assistance with reasonable and necessary travel expenses when you obtain prior approval and are required to travel more than 75 miles from your permanent residence to reach the facility where the covered transplant procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility, and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. You must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Ws when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Limits

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

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

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

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

Medical Supplies, Durable Medical Equipment, and Appliances

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

Medical and Surgical Supplies

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

Durable Medical Equipment

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

Prosthetic Devices

We cover purchase, fitting, needed changes, repairs, and replacements of prosthetic devices and supplies that:

- Replace all or part of a missing body part and its adjoining tissues; or
- Replace all or part of a permanently ineffective or non-functioning body part.

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

Benefits for prosthetic devices include:

- Either one set of standard prescription glasses or one set of contact lenses (whichever is right for the health problem) when needed to replace human lenses absent at birth or lost through intraocular Surgery, ocular injury or for the treatment of keratoconus or aphakia;
- Breast prostheses and two surgical bras each Benefit Period after a mastectomy; and
- The first wig after cancer treatment.

Orthopedic Appliances

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

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

Hearing Aid Services

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

- Audiological testing to measure the level of hearing loss and to choose the proper make and model of a hearing aid. These evaluations will be provided under other benefits of this "Benefits/Coverage (What Is Covered)" section for diagnostic services;
- Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment. We cover auditory training when it is offered using approved professional standards. Initial and replacement hearing aids will be supplied every 5 years, a new hearing aid may be a covered service when alterations to your existing hearing aid cannot adequately meet your needs or be repaired; and
- Visits for fitting, counseling, adjustments and repairs after receiving the covered hearing aid.

Dental Related Services

Accident-Related Dental Services

This Booklet is not meant to provide or replace dental insurance. But benefits are given for dental costs due to an accident if you meet all of the following rules:

- Dental services, supplies and appliances are needed because of an accident. The accident must have caused other major bodily injuries outside the mouth or oral cavity;
- Care must be for injuries to your sound natural teeth;
- Care must be needed to fix your teeth to the condition they were in just before the accident;
- The first dental services must be performed within 90 days after your accident; and
- All services must be performed within one year after your accident. Services after one year are not covered even if you still have coverage with Us.

Benefits for restorations are limited to those services, supplies, and appliances that We decide are appropriate in restoring the mouth, teeth, or jaws to the condition they were in just before the accident.

Dental Anesthesia

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

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

Cleft Palate and Cleft Lip Conditions

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

- Orofacial Surgery;
- Surgical care and follow-up care by plastic surgeons and oral surgeons;
- Orthodontics and prosthodontic treatment;
- Prosthetic treatment such as obturators, speech appliances, and prosthodontic; and
- Prosthodontic and surgical reconstruction for the treatment of cleft palate and/or cleft lip.

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

Other

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

Mental Health, Alcohol Dependency and Substance Dependency Services

We cover inpatient services, outpatient services and Doctor office services for the care of Mental Health Conditions, Alcohol Dependency or Substance Dependency. These services include diagnosis, crisis intervention and short-term care of Mental Health Conditions and for rehab of Alcohol Dependency or Substance Dependency.

Coverage for mental health care is for those conditions listed in the current version of the International Classification of Diseases, in the chapter titled "Mental Disorders." Mental Health Conditions are those that have a psychiatric diagnosis or that need specific psychotherapeutic care. Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) care is covered under this section if the services are given by a mental health Provider.

Alcohol Dependency and Substance Dependency benefits are for acute medical detox and for rehab. This care is covered when given by an Alcoholism Treatment Center. Alcohol Dependency or Substance Dependency is what happens when you use alcohol or other drugs in a way that harms your health or destroys your ability to control your actions. The main reason for medical detox is to get rid of the toxins in your body, and check your heart rate, blood pressure and other vital signs. Medical detox helps with your withdrawal signs and it gives you medicines as needed. Rehab includes the services and treatment listed below, to help you stop abusing alcohol or drugs.

Unless it is an Emergency, if your care is not listed below, it will only be covered if We gave Preauthorization before the services are received. Only the services received from the Doctor listed on the Preauthorization would be covered.

Inpatient Services. Inpatient care to treat Mental Health Conditions, Alcohol Dependency or Substance Dependency includes:

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

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

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

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

Preauthorizations. Your Doctor should call Our behavioral health administrator to find out Medical Necessity needs, correct treatment level and proper setting. Non Emergency inpatient services need Preauthorization. See the "How to Access Your Services and Obtain Approval of Benefits" section for information. Our behavioral health administrator must be told about all Emergency inpatient admissions the day after you have been admitted unless you are unable to contact Us.

Retail Pharmacy/Home Delivery Pharmacy Prescription Drugs

Our outpatient pharmacy benefits are for medications filled at a Retail Pharmacy or Home Delivery Pharmacy. Coverage is provided for In-Network and Out-of-Network Retail Pharmacies and for In-Network Home Delivery Pharmacies. All Prescription Drugs must be on Our Prescription Drug List to be covered.

Outpatient pharmacy services do not include services received in the Hospital as an inpatient, if a medical supply, durable medical equipment or appliance or when provided by a Specialty Pharmacy. See this "Benefits/Coverage (What Is Covered)" section for other Covered Services covered by the Booklet. Specialty Pharmacy Drugs listed on Our Specialty Drug List must be filled at a Specialty Pharmacy. See this "Benefits/Coverage (What Is Covered)" section for more information.

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

For certain Prescription Drugs, the prescribing Doctor may be asked to provide additional information so that We can determine if Medically Necessary. We may establish quantity limits for specific Prescription Drugs. The PBM in consultation with Us also promotes and enforces the appropriate use of medications by reviewing for improper dosage, potential drug to drug interactions or drug-disease state interactions.

You must first satisfy your Deductible then Covered Services are subject to a Copayment when they are received from an In-Network Retail Pharmacy. If you have the prescription filled at a In-Network Home Delivery Pharmacy or Out-of-Network Retail Pharmacy then they are not subject to a Copayment and are instead subject to Deductible and the Out-of-Pocket Annual Maximum. See the *Schedule of Benefits* to determine the associated cost share.

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

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

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

We have established a Pharmacy and Therapeutics (P&T) Committee, which is made up of health care professionals, including nurses, pharmacists and doctors. The purpose of this committee is to help in determine clinical appropriateness of drugs, assignments of drugs, Drug List inclusion, and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, before authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determination of tiers is made by Us using information from the P&T Committee. In addition We use the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter choices and where appropriate, certain clinical economic factors.

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

Each prescription received from an In-Network Retail Pharmacy is subject to a Copayment after you have satisfied your Deductible. Your Copayment amount is based upon the above and which tier the Prescription Drug falls under as follows:

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

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

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

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

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

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

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

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

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

- Prescription Drugs, including self-administered injectable drugs;
- Injectable insulin and syringes used for administration of insulin;
- Oral contraceptive drugs and contraceptive devices;
- Certain supplies, equipment and appliances (such as those for diabetes). You may contact Us to determine supplies covered through a pharmacy; and
- Smoking cessation Prescription Drugs.

For In-Network Retail Pharmacy services, after the Deductible is satisfied each prescription is subject to a Copayment. If the prescription order includes more than one covered drug or supply, a separate Copayment is required for each covered drug or supply. The Copayment will be the lesser of your Copayment, or the Prescription Drug Maximum Allowed Amount. The Copayment will not be reduced by any discounts, rebates or other funds received by Us or the PBM from drug manufacturers, or similar vendors and/or funds received by Us and or the PBM. We will not pay for a covered drug or supply unless the Prescription Drug Maximum Allowed Amount is more than the Copayment that you have to pay. See *the Schedule of Benefits* to determine the associated Copayment.

For in-Network Home Delivery Pharmacy and Out-of-Network Retail Pharmacy services, each prescription is subject to the Deductible and any Coinsurance. If the prescription order includes more than one covered drug or supply, a separate Deductible and any Coinsurance is required for each covered drug or supply. The Deductible and any Coinsurance is based on the Prescription Drug Maximum Allowed Amount. The Deductible and any Coinsurance will not be reduced by any discounts, rebates or other funds received by Us or the PBM from drug manufacturers, or similar vendors and/or funds received by Us and or the PBM. We will not pay for a covered drug or supply unless the Prescription Drug Maximum Allowed Amount is more than the Deductible and any Coinsurance that you have to pay.

You are limited a 30-day supply of a Prescription Drug if obtained at an In-Network or Out-of-Network Retail Pharmacy or up to a 90-day supply if received through the In-Network Home Delivery Pharmacy. When Medically Necessary, a vacation override is available with applicable Copayment and/or Deductible and Coinsurance if you are traveling out of Our Service Area.

The Half-Tablet Program will allow you to pay a reduced Copayment and/or Deductible and Coinsurance on selected "once daily dosage" medications. The Half-Tablet Program allows you to obtain a 30-day supply (15 tablets) of the higher strength medication when written by a Doctor to take "1/2 tablet daily" of those drugs on the approved list. The P&T Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and your decision to take part should follow consultation with and agreement by your Doctor. This program is only available through a Retail Pharmacy or Home Delivery Pharmacy. To get a list of the products available on this program contact Member services.

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

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

Prescription Drugs will always be dispensed as ordered by your Provider and by applicable state pharmacy regulations. You may request, or your Provider may order, a Brand Name Drug. However, if a Generic Drug is available, you will need to pay the cost difference between the Generic Drug and Brand Name Drug. The difference in cost is in addition to your Copayment for the drug. The cost difference between the Generic Drug and Brand Name Drug does not go towards your Out-of-Pocket Annual Maximum. By law, Generic Drugs and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics as a rule saves money, yet provides the same quality. We keep the right to remove certain higher cost Generic Drugs from this policy.

Home Delivery Pharmacy

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

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

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

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

You will receive refill forms and a notice that shows the number of refills your Doctor ordered in the package with your drugs. To order refills, you must have used 75% of your home delivery prescription. You may use Our website at www.anthem.com under MyHealth or contact Our Member services to obtain the mailing address for the Home Delivery Pharmacy.

Specialty Pharmacy Drugs

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

Specialty Pharmacy Drugs are high-cost, injectable, infused, oral or inhaled medications that as a rule need close supervision and monitoring by a medical professional. These drugs often require special handling such as temperature controlled packaging and overnight delivery and often cannot be filled at a Retail Pharmacy or through a Home Delivery Pharmacy. Benefits are only provided when you get your specialty drugs from an In-Network Specialty Pharmacy for those Specialty Pharmacy Drugs included on the Medical Provider Administered Specialty Drug List and Specialty Drug List.

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

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

The Outpatient Specialty Pharmacy benefits available under this Booklet are provided by Our Specialty Pharmacy. Our Specialty Pharmacy is a full service Specialty Pharmacy which sends medications to you by overnight mail or mail service for up to a 30-day supply (you cannot pick up your medication from Our Specialty Pharmacy). Our Specialty Pharmacy is not a Retail Pharmacy or a Home Delivery Pharmacy.

We have established a Pharmacy and Therapeutics (P&T) Committee, which is made up of health care professionals, including nurses, pharmacists and doctors. The purpose of this committee is to help determine clinical appropriateness of

drugs, assignments of drugs, and advising on programs to help improve care. Such programs may include, but are not limited to, drugs utilization programs, before authorization criteria, therapeutic conversion programs, cross-branded initiatives, drugs profiling initiatives and the like.

The determination of tiers is made by Us using information from the P&T Committee. In addition We use the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter choices and where appropriate, certain clinical economic factors.

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

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

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

Each prescription received is subject to a Copayment after you have satisfied your Deductible. Your Copayment amount is based upon the above and which tier the Specialty Pharmacy Drug falls under as follows:

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

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

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

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

Prescription Drugs will always be dispensed as ordered by your Provider and by applicable state pharmacy regulations. You may request, or your Provider may order, a Brand Name Drug. However, if a Generic Drug is available, you will need to pay the cost difference between the Generic Drug and Brand Name Drug. The difference in cost is in addition to your Copayment for the drug. The cost difference between the Generic Drug and Brand Name Drug does not go towards your Out-of-Pocket Annual Maximum. By law, Generic Drugs and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics as a rule saves money, yet provides the same quality. We keep the right to remove certain higher cost Generic Drugs from this policy.

After the Deductible is satisfied each prescription is subject to a Copayment. If the prescription order includes more than one covered drug or supply, a separate Copayment is required for each covered drug or supply. The Copayment will be the lesser of your Copayment, or the Prescription Drug Maximum Allowed Amount. The Copayment will not be reduced by any discounts, rebates or other funds received by Us or the PBM from drug manufacturers, or similar vendors and/or funds received by Us and or the PBM. We will not pay for a covered drug or supply unless the Prescription Drug Maximum Allowed Amount is more than the Copayment that you have to pay. See *the Schedule of Benefits* to determine the associated Copayment.

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

From time to time We may start various voluntary programs to encourage you to use more cost-effective or clinically-effective drugs. This includes but is not limited to using Generic Drugs, home delivery drugs, over-the counter, or preferred products. Such programs may involve reducing or waiving Copayment for certain drugs or preferred products

for a limited period of time. We may stop a program at any time. If you are participating in a program that We have stopped We will give you at least a 30 day advance written notice of the discontinuance.

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

Exception Process for Specialty Pharmacy Drugs

If you or your Provider believes that you should not be required to get your Specialty Pharmacy Drugs from a Specialty Pharmacy, you must follow the exception process which is available from Our Member services or at www.anthem.com.

Clinical Trials

Benefits will be provided for Routine Patient Care costs during a clinical trial if all of these conditions are met (see the definition of Routine Patient Care in the "Definitions" section of this Booklet):

- The treating Doctor recommends participation in the clinical trial after determining that participation has the potential to give you some therapeutic benefit;
- We approve the trial or study under the September 19, 2000, Medicare National Coverage Decision as it related to clinical trials;
- The treating Provider is a certified, registered, or licensed. The Provider has to work within the scope of his/her expertise. The facility and staff giving the care have the experience and training to provide treatment in a competent manner;
- Before to participation in a clinical trial or study, you have signed a consent indicating that you have been informed of the procedure and whatever risks it has along with alternative treatments. and that any coverage is in accordance with this Booklet (including the application of out of network cost shares); and
- You have a condition that is disabling, is getting worse or threatens your life.

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

This section talks about the items that are not covered. The items here are not Covered Services under this Booklet. The list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. Just because a service is not mentioned below does not mean it will be covered. It is important to know that in the "Benefits/Coverage (What Is Covered)" section and in other parts of the Booklet there are limits, conditions, and exclusions which apply, even if no mentioned below. The list below is meant as an aid to show common items which are not covered.

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

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

18. Routine exams and shots that are needed as a condition of employment, for licensing, sport programs, insurance, church, or camp;

19. For private duty nursing services, except when provided through the Home Health Services or Hospice Care services under the "Benefits/Coverage (What Is Covered)" section of this Booklet;

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

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

22. For complications arising from non-Covered Services and supplies;

23. Related to your leaving a Hospital or other facility against the medical advice of the Doctor;

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

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

26. Breast reduction Surgery (reduction mammoplasty) or services related to it, except as required by law;

27. For any Pre-Existing Condition during the waiting period as noted in "Eligibility" section of this Booklet;

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

29. For anything that occurs as a result of any act of war, declared or undeclared, while serving in the military, or services and supplies furnished by a military facility for disabilities connected to military service;

30. For a condition resulting from a riot, civil disobedience, nuclear explosion or nuclear accident;

31. For testing or care that has been ordered by a court unless Medically Necessary and preauthorized by Us;

32. For which you have no legal obligation to pay in the absence of this or like coverage;

33. That you get from a dental or medical department run by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;

34. Prescribed, ordered or referred by, or received from, a member of your immediate family (parent, child, spouse, sister, brother or self);

35. For filling out claim forms or charges for medical records or reports, unless otherwise required by law;

36. For missed or canceled appointments;

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

38. For Custodial Care, or domiciliary or convalescent care, whether or not recommended or performed by a professional;

39. For foot care to improve comfort or appearance. This includes, but not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails;

40. For sex change Surgery and related services, or the reversal of that;

41. For marital counseling or personal growth;

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

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

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

45. Services to reverse voluntarily induced sterility;

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

47. For experimental infertility procedures and non-Medically Necessary infertility procedures including, but not limited to artificial insemination, In-Vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT);

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

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

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

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

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

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

54. For peripheral bone density scans;

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

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

57. 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;

58. Provided or billed by a residential treatment center, school, halfway house, Custodial Care Facility for the developmentally disabled, or outward bound program, even if psychotherapy is included;

59. For rolfing therapy, myotherapy or prolotherapy;

60. For Ambulance transportation if you could have been transported by private vehicle or by commercial or public transportation without putting your health or safety in danger;

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

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

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

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

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

66. Services received from Out-of-Network Providers for the following: acupuncture, chiropractic, durable medical equipment and supplies (including oxygen and diabetic supplies and equipment), home health services, except as provided in this Booklet, and human organ and tissue transplants;

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

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

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

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

71. Self-administered drugs, including Specialty Pharmacy Drugs, purchased through bought or provided by a Doctor's office;

72. For massage therapy any manipulative techniques or procedures which are not generally accepted in a majority of states' massage therapy licensing boards. Massage therapy supplies including but not limited to lotions;

73. For acupuncture services mainly for the purpose of weight control, related to menstrual cramps and addiction including smoking cessation;

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

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

Human Organ and Tissue Transplant Services:

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

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

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

4. For any transplant, treatment, procedure, facility, equipment, drug, device, service or supply that requires federal or other governmental agency approval and such approval is not granted at the time services are provided, including any service or supply associated with or provided in follow-up;

5. For transplants of organs other than those listed in "Benefits/Coverage (What Is Covered)" section in this Booklet including non-human organs;

6. Procurement of a donor organ which has been sold rather than donated;

7. Related to artificial and/or mechanical hearts or for subsequent services and supplies for a heart condition as long as any of the artificial or mechanical heart remains in place. This exclusion includes services for implantation, removal and complications; or

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

    - Alcohol, tobacco, other non food items;
    - Standard Meals;
    - Child care;
    - Mileage within the medical transplant facility city;
    - Rental car, buses, taxis, or shuttle services, except those that We approve;
    - Frequent flyer miles;
    - Coupons, vouchers, or travel tickets;
    - Prepayment or deposits;
    - Services for a condition that is not directly related, or a direct result, of the transplant;
    - Phone calls;

- Laundry;
- Postage;
- Entertainment;
- Interim visits to a medical care facility while waiting for the actual transplant procedure;
- Travel costs for donor companion/caregiver;
- Return visits for the donor for a treatment of a condition found during the evaluation.

Online Clinic Visits:

1. Non Covered Services include, but are not limited to communications used for:
   - Reporting normal lab or other test results;
   - Reporting normal lab or other test results;
   - Office appointment requests;
   - Billing, insurance coverage or payment questions;
   - Requests for referrals to doctors outside the online care panel;
   - Benefit precertification;
   - Physician to Physician consultation

Retail Pharmacy Prescription Drugs:

1. Prescription Drugs and supplies received from an Out-of-Network pharmacy;
2. Prescription Drugs and supplies received as an inpatient in a hospital or other covered inpatient facility, except where covered as part of the inpatient stay;
3. Non-legend Prescription Drugs, unless otherwise specified in this Booklet;
4. Drugs prescribed for weight control or appetite suppression;
5. Medication or preparations used for Cosmetic purposes to promote hair growth, prevent hair growth, or medicated cosmetics. These included but are not limited to Rogaine®, Viniqa®, and Tretinoin (sold under such brand names as Retin-A®);
6. Drugs not approved by the FDA;
7. Any new FDA approved drug product or technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA new drug approval or other applicable FDA approval. We may at Our sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology;
8. Any medications used to treat infertility;
9. Delivery charges for prescriptions;
10. Charges for the administration of any drug unless dispensed in the Doctor's office or through home health care;
11. Drugs which are provided as samples to the Provider;
12. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse;
13. Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of the "Benefits/Coverage (What Is Covered)" section;
14. Therapeutic devices or appliances, including support garments and other nonmedicinal supplies (regardless of intended use);
15. Nonprescription and over-the-counter drugs, including herbal or homeopathic preparations, and Prescription Drugs that have a Clinically Equivalent alternative, even if written as a prescription;

16. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) except for injectable insulin;

17. Prescription Drugs, which are dispensed in quantities or refill frequency which exceed the applicable limits established by Us, at Our sole discretion;

18. Refills of prescriptions in excess of the quantity prescribed by the Provider, or refilled more than one year from the date prescribed;

19. Prescription Drugs dispensed for the purpose of international travel;

20. Prescription Drugs which have been obtained through a Home Health Agency;

21. Replacement of lost or stolen Prescription Drugs; or

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

Specialty Pharmacy Drugs

1. Specialty Pharmacy Drugs which are not provided through the specialty program, including but not limited to Specialty Pharmacy Drugs that are provided through a Doctor's office or Home Health Agency;

2. When benefits are provided under the Specialty Pharmacy benefits they will not be provided under the "Benefits/Coverage (What Is Covered)" section of this Booklet; or

3. Outpatient Prescription Drugs or medications that are Specialty Pharmacy Drugs received from a Retail Pharmacy. You will pay the full cost of the Specialty Pharmacy Drug when received from a Retail Pharmacy since those services should have been received from a Specialty Pharmacy.

Chiropractic Therapy

1. Services for preventive, maintenance or well care;

2. Drugs, vitamins, nutritional supplements or herbs from a chiropractor;

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

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

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

6. Treatment for weight control;

7. Lab services from a chiropractor;

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

9. Inpatient services from a chiropractor;

10. Manipulation under Anesthesia;

11. Treatment of non-neuromusculoskeltal disorders; or

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

Clinical Trials

1. Any part of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;

2. Any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;

3. Expenses not related to taking part in the clinical trial or study. These include, but is not limited to, travel, housing, and other expenses that a participant or person with a participant may incur;

4. An item or service that is provided solely for data collection or analysis that is not directly related to the clinical management of the participant;

5. Costs for the management of research relating to the clinical trial or study;

6. Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under this Booklet; or

7. Any service or procedure related to the diagnosis, treatment or prevention of complications related to a clinical trial.

Pre-existing Conditions

You and your Dependents may be subject to a pre-existing condition limitation period. If you have a pre-existing condition, We will not pay for any services related to such condition during the limitation period. We have the right to review your medical information if a pre-existing condition exists. A limitation period may be retroactively added if such a pre-existing condition exists.

A pre-existing condition is any condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately preceding the date of your enrollment in such a plan, or, if earlier, the first day of the waiting period for such enrollment. Pregnancy is not a pre-existing condition. In addition, Members who are under 19 years of age are not subject to a pre-existing condition limitation period.

We will **not** pay for anything related to a pre-existing condition for six straight months after the date of enrollment or, if earlier, the first day of the waiting period if:

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

We shall not use the waiting period to see if a condition is pre-existing.

We will **not** pay for anything related to a pre-existing condition for six straight months after the date of enrollment or, if earlier, the first day of the waiting period if:

- You had no prior coverage within 90 days of enrollment and the Member waives coverage with Us initially;
- You did not enroll within 31 days of when you were eligible;
- You did not enroll within 31 days of a special enrollment period; and
- You were not enrolled with the employer's prior health plan and you enroll as part of a new group with Us.

We will not use the waiting period to see if a condition is pre-existing.

NOTE: New entrants who enroll on time (within 31 days of eligibility) and have proper prior coverage within 90 days of enrollment, are not subject to the exclusion above. The waiting period is not counted to see if there was proper prior coverage.

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

Note: You have the right to get a "Certificate of Creditable Coverage" from your prior plan. Please call Us for help in getting such certificate or if you have any questions.

MEMBER PAYMENT RESPONSIBILITY

Cost Sharing Requirements

Cost Sharing is how We share the cost of health care services with you. It means what We are responsible for paying and what you are responsible for paying. You meet your Cost Sharing requirements through your payment of Copayments, Deductibles and Coinsurance (as described below). How much you have to pay depends on the choices you make of Providers. For example, if you choose to use a participating Provider or participating facility, your out-of-pocket costs may be less than if you choose a non-participating Provider or non-participating facility. Your Cost Sharing requirements are based on the Maximum Allowed Amount.

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

In their contracts, participating Providers agree to accept Our Maximum Allowed Amount as payment in full for Covered Services. We determine a Maximum Allowed Amount for all procedures performed by Providers.

The contracts between Us and our participating Providers include a "hold harmless" clause which provides that you cannot be responsible to the Provider for claims owed by Us for health care services covered under this Booklet. Non-participating Providers do not have that rule. They can charge or "balance bill" you for any amount of their bill which we do not pay. This "balance billing" cost can be large, and is on top of, and does not count toward, your Cost Sharing obligation.

Maximum Allowed Amount

This section describes how We determine what we pay for Covered Services. Reimbursement of Covered Services given to you by a participating and non-participating Provider is based on your plan's Maximum Allowed Amount. Please see Inter-Plan Programs and BlueCard® Program in the "Claims Procedure (How to File a Claim)" section for more information.

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

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

You will be required to pay a portion of the Maximum Allowed Amount if you have not yet met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a non-participating provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be large.

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

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

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is participating or non-participating.

A participating Provider is a Provider who is in the Provider network for this specific health benefits plan. For Covered Services performed by a participating Provider, the Maximum Allowed Amount for this plan is the rate the Provider has agreed with Us to accept as reimbursement for the Covered Services. Because participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount if you have not yet met your Deductible or have a Copayment or Coinsurance. Please call Member services for help in finding a participating Provider or visit www.anthem.com.

Providers who have not entered into a PPO Provider contract with Us are non-participating Providers.

For Covered Services you receive from a non-participating Provider, the Maximum Allowed Amount for this plan will be one of the following as determined by Us:

1. An amount based on Our non-participating Provider fee schedule/rate, which We have established at Our discretion, and which We may modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with Us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services (CMS) for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on the level and/or method of reimbursement used by CMS for the same services or supplies; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care; or

4. An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through Care Management; or

5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Unlike participating Providers, non-participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This "balance billing" amount can be large. Choosing a participating Provider will likely result in lower out of pocket costs to you. Please call Member services for help in finding a participating Provider or visit Our website at www.anthem.com.

Member services is also available to assist you in determining your plan's Maximum Allowed Amount for a particular service from a non-participating Provider. In order for Us to assist you, you will need to get from your Provider the specific procedure code(s) and diagnosis code(s) for the services they will give you. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Member services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

Member Cost Share

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

Your cost share amount and out-of-pocket limits may vary depending on whether you receive services from a participating Provider or non-participating Provider. This means you may be required to pay higher cost share amounts or may have limits on your benefits when using non-participating Providers. Please see the *Schedule of Benefits* for your cost share amounts and limitations. You can also call Member services to find out your health benefit coverage or cost share amounts which can vary by the type of Provider you use.

We will not pay for services that are not covered by this Booklet and you will be responsible for the total amount billed by your Provider. It doesn't matter if the services are performed by a participating Provider or non-participating Provider. Services specifically excluded by the terms of this Booklet and those received after benefits have been exhausted are both non-Covered Services. Benefits may be exhausted by exceeding, for example, the lifetime maximum, benefit caps or day/visit limits.

Sometimes you may only be asked to pay the lower In-Network Cost Sharing amount when you use a non-participating Provider. For example, if you go to a In-Network/Participating Hospital or Provider Facility you may receive Covered Services from a non-participating Provider like a radiologist, anesthesiologist or pathologist. If you did not know that the Provider is not participating, and that Provider is employed by or contracted with a Participating Hospital or facility, you will

pay the In-Network cost share amounts. You will not have to pay more for the Covered Services than you would have had to pay if it had been received from a participating Provider.

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

Authorized Services

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

Copayment

Copayments may be required for Covered Services. A Copayment is a set, fixed-dollar amount you must pay to receive a specific service. You are required to pay your Copayments to Providers for specific Covered Service as listed in the *Schedule of Benefits*. You need to pay Copayments directly to the Provider. You must pay your Copayment even after meeting Deductible and/or Coinsurance requirements or Out-of-Pocket Annual Maximum. Copayment amounts do not apply to Deductible and/or Out-of-Pocket Annual Maximum requirements.

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

In addition to any Copayment required, you are responsible for any applicable Deductible and/or Coinsurance for additional services received, e.g., laboratory and x-ray services.

Deductible

A Deductible is a set dollar amount for Covered Services that you must pay within your Benefit Period before We pay for Covered Services. Deductibles do not contribute toward your Out-of-Pocket Annual Maximum. The Deductible amount is listed in the *Schedule of Benefits*.

There are two separate Deductibles: one for participating Providers and one for non-participating Providers. Charges from a participating Provider cannot be applied toward meeting the Out-of-Network Deductible, and charges from a non-participating Provider cannot be applied toward meeting the In-Network Deductible. If a service is subject to a Copayment, it is not subject to the Deductible.

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

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

The family Deductible applies to newborn and adopted children for the first 31-day period following birth or adoption if the child is enrolled or not enrolled following the 31-day period.

Portability of Deductible and Out-of-Pocket - When you change to one of Our Colorado PPO or HMO plans that has Deductible and Coinsurance, you may be able to apply the costs of Covered Services incurred and applied to the Deductible and Coinsurance from the prior coverage to your new coverage. Portability is based on the particular benefit design purchased. For details, please contact Our Member services.

Prior Deductible Credit - When your employer group changes to Our employer group health care coverage from some other health insurance carrier you may be eligible for prior Deductible credit when you first enroll. Prior Deductible credit is the term used when claims for services or supplies that were applied to the Deductible requirements of the prior carrier. These amounts can be toward the Deductible for Our coverage. Prior Deductible credit is not given to you at other times and is only given as part of the original enrollment of the employer group with Us. You must apply for prior Deductible credit and send written notice of the amount applied by the prior health insurance carrier. Our Member services needs to get this no later than 180 days after the employer's Effective Date with Us. Send to:

Anthem Blue Cross and Blue Shield
Member Services Attn: Prior Deductible Credit
700 Broadway
Denver, CO 80217-5747

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

Coinsurance/Out-of-Pocket Annual Maximum

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

You pay the Coinsurance percentage for Covered Services until the Out-of-Pocket Annual Maximum is reached for your Benefit Period. Once the Out-of-Pocket Annual Maximum is reached, We pay 100 percent of any remaining eligible charges for the rest of your Benefit Period. In-Network and Out-of-Network Coinsurance amounts are separate and do not apply toward each other. You will always be responsible for the difference between Billed Charges and the Maximum Allowed Amount for non-participating Providers, even after reaching the Out-of-Pocket Annual Maximum for Out-of-Network services. The difference between Billed Charges and the Maximum Allowed Amount for non-participating Providers does not apply towards your Out-of-Pocket Annual Maximum. In addition, Deductibles are excluded from the Out-of-Pocket Annual Maximum.

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

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

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

Benefit Period Maximum

Some Covered Services have a maximum number of days, visits or dollar amounts that We will allow during a Benefit Period. When the Deductible is applied to a Covered Service that has a maximum number of days or visits, the maximum benefits may be reduced by the amount applied to the Deductible, whether or not the Covered Service is paid by Us. These maximums apply even if you have satisfied the applicable Out-of-Pocket Annual Maximum. See the *Schedule of Benefits* for those services which have a Benefit Period Maximum.

If you leave this plan, and go on to a new plan with Us in the same Benefit Period, all covered benefits that have a Benefit Period maximum or lifetime maximum will be carried over to the new plan. For instance, if a benefit has a limit of one visit per Benefit Period and you received that benefit under the prior coverage, then you are not eligible under the new plan for the same benefit until the Benefit Period ends, as benefits have been exhausted for your Benefit Period.

CLAIMS PROCEDURE (How to File a Claim)

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

If a non-participating Provider does not bill Us directly, you must file the claim. To get claim forms, call Our Member services or print it from our website at www.anthem.com. If We do not give you a claim form within 15 days of your request, you may submit written proof of the claim and will be considered to have complied with the rules of this Booklet for submitting a claim. You must complete the claim form and attach the itemized bill from the Provider. Balance due statements, cash register receipts and cancelled checks are not accepted. All information on the claim form and itemized bill must be readable. When traveling outside the country, you should obtain itemized bills translated to English. Charges for Covered Services should be stated in terms of United States dollar. To find out the dollar amount, use the exchange rate as it was on the date you received care. If information is missing on the claim form or is not readable, the form will be returned to you. The information contained on the itemized bills will be used to determine benefits, so it must support information reported on the submitted claim form. The claim form has detailed instructions on how to complete the form and what information is needed.

We pay the benefits of this Booklet directly to non-participating Providers, depending on whether you have authorized an assignment of benefits. We may require a copy of the assignment of benefits for Our records. If We pay you directly, you are responsible for paying the Provider for all charges. These payments fulfill our obligation to you for those services.

A separate claim form is required for each non-participating Provider for which you are requesting payment.

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

Where and When to Send Claims - A claim must be filed **within 365 days** after the date of service. Any claims filed after this limit may be refused. But if you can show that it wasn't possible to file within this time limit, and that you filed your claim promptly afterwards, then We will not consider the claim late.

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

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

Anthem Claims
P.O. Box 5747
Denver, CO 80217-5747

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

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

Out-of-Area Covered Services - Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. These are referred to generally as "Inter-Plan Programs." When you obtain Covered Services outside of Anthem's service area, the claims may be processed through one of these Inter-Plan Programs, which include the BlueCard Program, described below. They may include negotiated national account arrangements between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when you access medical care outside Anthem's service area, you will obtain it from Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other area ("Host Blue"). But in some cases, you may obtain care from non-participating Providers. Anthem's payment practices in both instances are generally described below.

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

Whenever you obtain Covered Services outside Anthem's service area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

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

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider or Provider group. Sometimes such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve: types of settlements; incentive payments; and/or other credits or charges.

Estimated and average pricing arrangements also take into account certain adjustments to their basic rates. These may be made to correct for an over- or underestimation of modifications of changes of the past pricing for the types of transactions noted above. But, such adjustments will not affect the price on the claim that Anthem will use to determine the amount you pay.

Also, laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If any state law mandates other liability calculation methods, including a surcharge, Anthem calculates a Member’s liability for any Covered Services according to applicable law.

Care Outside the United States BlueCard Worldwide - Prior to travel outside the United States, check with your employer or call the Member services number on the Health Benefit ID Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and We recommend:

- Before leaving home, call the Member services number on the Health Benefit ID Card for coverage details;
- Always carry the current Health Benefit ID Card;
- In an Emergency, go directly to the nearest Hospital; and
- The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a medical professional, will arrange a physician appointment or hospitalization, if needed.

  Call the Service Center in these non-emergent situations:

- You need to find a Doctor or Hospital or need medical assistance services. An assistance coordinator, along with a medical professional, will arrange a physician appointment or hospitalization, if needed;
- You need to find a Doctor or Hospital or need medical assistance services. An assistance coordinator, along with a medical professional, will arrange a physician appointment or hospitalization, if needed; and
- You need to be hospitalized or needs inpatient care. After calling the Service Center, you must also call Us for Preauthorization, at the phone number on the Health Benefit ID Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment information:

- Participating BlueCard Worldwide Hospital - In most cases, when you make arrangements for hospitalization through BlueCard Worldwide, you should not need to pay upfront for inpatient care at participating BlueCard Worldwide Hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Copayments and Coinsurance) normally paid. The Hospital should submit the claim on your behalf; and
- Doctors and/or non-participating Hospitals - You will need to pay upfront for outpatient services, care received from a Doctor, and inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing:

- The Hospital will file the claim if the BlueCard Worldwide Service Center arranged the hospitalization. You will need to pay the Hospital for the out-of-pocket costs normally paid; and
- You must file the claim for outpatient and Doctor care, or inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the health care Provider and subsequently send an international claim form with the original bills to Us.

Claim Forms:

International claim forms are available from Us, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for submitting claims is on the form.

GENERAL POLICY PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

We may subcontract particular services to organizations or entities that are experts in certain areas. This may include Prescription Drugs, Mental Health Condition, Alcohol Dependency and Substance Dependency services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims payment or Member services duties on Our behalf.

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

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

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

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

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

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

Notice of Privacy Practices - We promise to protect the private nature of your medical information to the fullest extent of the law. In addition to various laws governing your privacy, We have our own privacy policies and procedures in place designed to protect your information. We are required by law to provide individuals with notice of Our legal duties and privacy practices. To obtain a copy of this notice, visit Our website at www.anthem.com or contact Our Member services.

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

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

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

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

Research Fees - We reserve the right to charge an administrative fee when a lot of research is necessary to reconstruct information that has already been given to you in Explanations of Benefits, letters or other documents.

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

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

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

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

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

- The Subscriber at the latest address in Our membership records; or
- The Subscriber's employer.

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

Receive Information About the Coverage and Benefits.

All plan Members may:

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

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

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

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

Assistance with Questions

If you have any questions about the plan, or whether it is a plan governed by ERISA you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance

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

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

Workers' Compensation

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

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

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

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

- You fail to file a claim within the filing period allowed by law;
- You get care that is not approved by workers' compensation insurance;
- Your employer fails to carry the required workers' compensation insurance. In this case, the employer becomes liable for any of the illness or injury costs related to your work; or
- You fail to follow any other terms of the Workers' Compensation Act.

Automobile Insurance Provisions

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

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

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

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

We may require proof that the auto policy has paid all primary benefits before making any payments under this Booklet. On the other hand, We may but are not required to pay benefits under this Booklet, and later coordinate with or seek

reimbursement under the auto policy. In all cases, upon payment, We are entitled to exercise Our rights under this Booklet and under applicable law against any and all potentially responsible parties or insurers. In that event, We may exercise the rights found in this section.

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

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

Third Party Liability: Subrogation and Right of Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness and another party or party(ies) agree or is ordered to pay money because of these injuries or when the Member received or is entitled to receive a Recovery because of these injuries or illnesses. Reimbursement or subrogation under this Booklet may only be permitted if you have been fully compensated, and, the amount recoverable by Us may be reduced by a proportionate share of your attorney fees and costs, if state law so requires.

Subrogation

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

- If you have been fully compensated, We have a lien against all or a portion of the benefits that have been paid to you from the following parties, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, your own insurer (for example, uninsured, underinsured, medical payments or no-fault coverage, or a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness. However, our Recovery cannot exceed the amount actually paid by Us under your policy as it relates to the injuries or illness that are the subject of the subrogation action; and

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

Right of Reimbursement

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

- You must reimburse Us to the extent of the health insurance benefits We paid on the Member's behalf from any Recovery, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, your own insurer (for example, underinsured, medical payments, or a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness;

- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of reimbursement; and

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

The Member's Duties

- You, a person who represents your legal interest, or beneficiary must tell Us right away the how, when and where an accident or event that resulted in your injury or illness. We must find out what happened and get all the details about the parties involved;

- You, a person who represents your legal interest, or beneficiary must work with Us in investigating, settling and protecting rights;

- You, a person who represents your legal interest, or beneficiary must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness;

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

Duplicate Coverage and Coordination of Benefits

We may coordinate benefits when you have duplicate coverage.

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

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

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

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

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

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

NOTE: Change in the people who manage the plan is considered continuous coverage. This means that the Effective Date of the coverage in that group is the Effective Date with the insurance company from the start, as long as there were no lapses in coverage. Further details about coordinating benefits for Members who hold two insurance policies and Medicare may be found under this section.

Duplicate Coverage on Spouses - When your spouse has group coverage through an employer and is an active worker, that coverage is primary for the spouse.

When the coverage carried by the spouse is through retiree or work that is no longer active, that coverage will be primary over the coverage carried by Our Subscriber.

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

Note: Information about coordinating benefits for Members who hold two insurance policies and Medicare may be found under this section.

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

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

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

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

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

The birthday rule is the guideline that determines which of two parents' insurance is primary coverage of the child. It applies as follows:

- When the terms of the court decree says that the parents share joint custody and both must provide health insurance; or
- When the terms of the court decree says that the parents share joint custody, without saying which parent is responsible for providing health insurance for the child

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

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

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

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

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

When a Member becomes eligible for Medicare due to a second entitlement, such as age, We remain primary. But this will only apply if the group coverage was primary at the point when the second entitlement took effect, for the duration of 30 months after becoming Medicare entitled or eligible due to ESRD. If Medicare was primary at the point of the second entitlement, then Medicare remains primary. There will be no 30-month coordination period for ESRD.

Members with Medicare and Two Group Insurance Policies - Based on the primacy rules, if Medicare is secondary to a group coverage, the primary coverage covering the Member will pay first. Medicare will then pay second, and the coverage covering the Member as a retiree or an employee that is no longer active or Dependent will pay third. The order of primacy is not based on the group coverage.

If Medicare is the primary payer due to Medicare primacy rules, then the rules of primacy for employees and their spouses will be used to determine the coverage that will pay second and third.

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

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

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

Payment of Benefits to Others - When payments that should have been made under this Booklet were made under any other coverage, We will have the right to pay to the other coverage any amount We decide to satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this Booklet, and with that payment We will satisfy in full Our liability.

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

TERMINATION/NONRENEWAL/CONTINUATION

Active Policy Termination

Your coverage ends when one of the following happens:

- On the date the Employer Master Contract between the employer and Us ends;
- On the Subscriber's death;
- When the Premium has not been paid;
- When you or your employer commits fraud or intentional misrepresentation of material fact; or
- When you are no longer eligible under the terms of the Employer Master Contract.
- When your employer gives Us written notice that you are no longer eligible. Coverage will end on the date of the notice or at the end of the month of the qualifying event. We reserve the right to recoup any benefit payments made for dates of service after the termination date.
- When We receive a 31-day advance written notice to end coverage for any Member. Coverage will end at the end of the month following the notification period or at the end of the month of the qualifying event. We will credit Premium paid in advance unless We do not receive the cancellation request at least 31 days before the Effective Date of the cancellation.
- When We cease operations.

Dependent Coverage Termination

To remove a Dependent from coverage, you must send us an enrollment application and change form 31 days before the Effective Date of the change. If we receive this after the requested Effective Date, the change will be effective on the date We are notified of the change. We reserve the right to recoup any benefit payments made after the termination date.

We will credit Premium paid in advance unless We do not get the enrollment application and change Form within 31 days before the Effective Date of the change or if We have paid any claims on behalf of the cancelled Dependent in the period for which the credit would be owed to the employer.

Coverage for a Dependent ends on the last day of the month immediately preceding the next monthly Premium due date following receipt of the request. It may also end when one of the following happens:

- At the end of the month when you notify Us in writing to cancel coverage for a Dependent;
- When the Dependent no longer qualifies as a Dependent. Such a Dependent has the right to seek COBRA or state continuation coverage;
- On the date of a final divorce decree or legal separation for a spouse. Such a Dependent has the right to seek COBRA or state continuation coverage;
- If there is coverage for designated beneficiaries, on the date a Recorded Designated Beneficiary Agreement is revoked or terminated. Such a Dependent does not have the right to seek COBRA continuation coverage; or
- At the end of the month when legal custody of a child placed for adoption ends.

Certificate of Creditable Coverage

When your coverage with Us ends, We will send you a Certificate of Creditable Coverage. This will tell you the length of your creditable coverage with Us. You may need this as proof of prior coverage if you want other health care coverage.

What We Will Pay for After Termination

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

When your coverage ends for any reason other than for nonpayment of Premium, fraud or abuse, We will continue coverage if you are being treated at an inpatient facility, until you are discharged or transferred to another level of care.

This is subject to the terms of this Booklet. The discharge date is seen as the first date on which you are discharged from the facility or transferred to another level of care. We will not cover the services you get after your discharge date.

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

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

Continuation of Coverage

Family and Medical Leave Act

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

State Continuation Eligibility and Notification

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

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

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

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

COBRA Eligibility and Notification

COBRA Eligibility - For employers with 20 or more employees, Subscribers and their Dependent who lose eligibility with a group may keep coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). You should call the employer for more details. COBRA coverage can last for 18, 29 or 36 months. The length of time you can have depends on the qualifying event(s) and only if the federal rules are met.

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

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

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

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

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

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

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

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

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

Termination of State Continuation Coverage or COBRA

Your continuation coverage ends when the continuation period ends.

Continuation coverage may end before the continuation period ends if:

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

Conversion

When state continuation or COBRA ends, Subscribers and their Dependents who were on the group's health plan may apply for conversion. Conversion may also be an option for Dependents (other than a spouse) who lose status as a Dependent. If state continuation or COBRA is not available, the Subscriber and Dependents must have been on the group plan for at least three months just before the group coverage ends to be eligible for conversion. **The conversion coverage must be the same type of coverage** (like PPO or HMO) that ended with Us. It must also be with one of the Basic or Standard plans. Conversion coverage is not an option if the group plan cancels its plan. Conversion coverage through Us is not available if the election period takes place after the group has replaced this coverage.

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

Conversion is not available to former employees of a group and their in the following times:

- When an employee is not a group because they were not on the group plan when the coverage ended;
- When the employee's coverage ends because they fail to pay their share of;
- When a was not on the group plan when the employee's coverage ended;
- When an employee or is covered by at the time they were eligible for conversion. Please call Us for coverage options; or
- When the employee or is covered for similar benefits by another health plan that would result in over-insurance according to Our standards.

Note: If you do not want or are not eligible for conversion, you can apply for an individual policy. The application is subject to the rules for individual coverage.

For groups of 50 employees or less, conversion is available to all employees if the group plan is cancelled by either Us or the employer for reasons other than other group coverage or fraud and abuse in getting coverage. Conversion is available even if the group coverage ends because the group did not pay. The conversion coverage will be group coverage under Our Basic or Standard Plans. The employer must tell each employee of the right to get conversion.

APPEALS AND COMPLAINTS

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

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

Complaints

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

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

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

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

Appeals

If We have denied a claim that you feel should have been covered, or handled in a different way, you can file an appeal. You can appeal a denial that was made by Us before the service is received. You can also appeal a denial on a service after it is received. An appeal can be filed verbally by calling Member service. An appeal can also be filed by writing to this address:

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

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

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

Internal Appeals

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

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

Expedited internal appeal - If you have an urgent case, you may request that your internal appeal be reviewed in a shorter time period. This is called an expedited internal appeal. You or your representative can ask for an expedited appeal if you had Emergency services but haven't been discharged from the Facility. Also, you can ask for an expedited appeal if the regular appeal schedule would:

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

Independent External Appeals

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

Your request for independent external review must be made within 4 months of receiving Our first level appeal decision, or within 60 days of receiving Our second level appeal decision. Generally, you have to have completed at least the first level internal appeal. But if We fail to handle the appeal according to applicable Colorado insurance law and regulations, you will be eligible to request independent external review.

Expedited external appeal - You can request an expedited independent external review, but only in certain cases. You will need a Doctor to certify to Us that you have a medical condition where following the normal external review appeal process would seriously jeopardize your life or health, would jeopardize your ability to regain maximum function or, if you're disabled, would create an imminent and substantial limitation of your ability to live independently. If it meets these conditions, your request for expedited external appeal can be filed at the same time as your request for an expedited internal appeal. But an expedited external appeal is not available where the service was already provided.

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

Grievances

If you have an issue or concern about the quality or services you receive from a participating Provider or Facility, you can file a grievance. The quality management department strives to resolve grievances fairly and quickly. You may call Member service or send a written grievance to:

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

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

Division of Insurance Inquiries

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

Binding Arbitration

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

Legal Action

Before you take legal action on a claim decision, you must first follow the process found in this section. You must meet all the requirements of this Booklet.

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

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

INFORMATION ON POLICY AND RATE CHANGES

Insurance Premiums

How Premiums are Established and Changed - Premiums are the monthly charges you and/or the employer must pay Us to get coverage. We figure out and set the required Premiums.

The employer is responsible for paying the employee's Premium to Us according to the terms of the Employer Master Contract. Employers may have you contribute to the Premium cost through payroll deduction. Some employer groups may choose to have your Premium determined by the age of the Subscriber, with Premium set by age brackets. We may change membership Premiums on the Anniversary Date, which we may assess when a Subscriber changes to a new five-year increment age bracket, e.g., age 25 through age 29. If the age of the Subscriber is misstated at enrollment, all amounts payable for the correct age will be adjusted and billed to the group.

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

DEFINITIONS

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

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

Alcohol Dependency - a condition in which you use alcohol in a way that damages your health or lose your ability to control your actions.

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

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

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

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

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

- General Anesthesia, also known as total body Anesthesia, puts you to sleep for a period of time; or
- Local Anesthesia causes loss of feeling or numbness in a specific area and is usually injected with a local anesthetic drug such as Lidocaine

Anniversary Date - the annual date on which your employer renews its coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Coinsurance - percentage of costs you share with Us after you meet the Deductible.

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

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

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

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

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

Covered Services - services, supplies or treatments which are:

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

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

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

Deductible - is the dollar amount of Covered Services, listed in the *Schedule of Benefits*, which you must pay before benefits begin under this Booklet.

Dependent - a Subscriber's legal spouse, common-law spouse, designated beneficiary, or child as defined in the "Eligibility" section of this Booklet.

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

Effective Date - the date coverage under this Booklet begins.

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

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

Experimental or Investigational -

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

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

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

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

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

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

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

- Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal;
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies;
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply;
- Documents of an IRB or other similar body performing substantially the same function;
- Consent documentation(s) used by the treating Physicians, other medical professionals or facilities, or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply;
- The written protocol(s) used by the treating Physicians, other medical professionals or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply;
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

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

Explanation of Benefits - a form sent by Us to you after you have filed a claim. It includes items such as the date of service, name of Provider, amount covered and patient balance.

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

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

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

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

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

Hospice Facility - a Facility Provider licensed by the Colorado Department of Public Health and Environment to provide Hospice Care in this state. A Hospice is a centrally administered program of palliative, supportive and interdisciplinary team services providing physical, psychosocial, spiritual and bereavement care for the terminally ill and their families to be available 24 hours a day, 7 days a week.

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

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

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

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

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

Long-Term Acute Care Facility - a place that gives long-term critical care services if you have serious illnesses or injuries.

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

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

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

Medical Provider Administered Specialty Drug List - a list of Specialty Pharmacy Drugs as determined by Us which you must get from the In-Network Specialty Pharmacy PBM and are billed under the medical benefit.

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

- Medically appropriate for and consistent with your symptoms and proper diagnosis or treatment of your condition, illness, disease or injury;
- Obtained from a Doctor or Provider;
- Provided in line with medical or professional standards;
- Known to be effective, as proven by scientific evidence, in improving health;
- The most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted. It will need to be consistent with recognized professional standards of care. In the case of a Hospital stay, also means that safe and adequate care could not be obtained as an outpatient;
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost);
- 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.

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

Member - the Subscriber or any Dependent who is enrolled for coverage under this Booklet. Also referred to in this Booklet as "you" or "your".

Mental Health Condition - mental conditions, including biologically based mental illness, that have a psychiatric diagnosis or that needs specific psychotherapeutic treatment, no matter what the underlying condition (for example, depression secondary to diabetes or primary depression). This term does not include autism.

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

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

Out-of-Network - a term for non-participating Providers that do not enter into a network contract with Us. Services received from a non-participating Provider, usually result in a higher out-of-pocket cost to you than services you get from a participating Provider.

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

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

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

Prescription Drug -

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

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

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

Legend Drug - a medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to show in the label, "Caution: Federal law prohibits dispensing without a prescription." Compounded drug that contain at least one such medicinal substance are considered to be Legend Drugs. Insulin is considered a Legend Drug under this Booklet.

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

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

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

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

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

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

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

Inpatient Facility Provider

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

Outpatient Facility Provider

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

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

Primary Care Provider - is typically an internal medicine Doctor, family practice Doctor, general practitioner, pediatrician, registered nurse, clinical nurse specialist, nurse practitioner or a Doctor assistant as allowed by Us.

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

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

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

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

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

Recovery - Recovery is money the Member, the Member's legal representative, or beneficiary receives whether by settlement, verdict, judgment, order or by some other monetary award or determination, from another, their insurer, or from any uninsured motorist, underinsured motorist, medical payments, personal injury protection, or any other insurance coverage, to compensate the Member as a result of bodily injury or illness to the Member. Regardless of how the Member, the Member's legal representative, or beneficiary or any agreement may characterize the money received, it shall be subject to the Third Party Liability: Subrogation and Right of Reimbursement under the "General Policy Provisions" section of this Booklet.

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

Routine Patient Care (associated with clinical trials) - means Covered Services under this Booklet that would be covered if you were not involved in either an experimental or clinical trial. However, such care does not include:

- Items and services normally given by research sponsors for free for anyone participating in the trial;
- Routine costs in clinical trials;
- Investigative items or services, including watching or stopping the complications; or
- Reasonable and necessary care from an Investigative item or service, including diagnosis or treatment of complications.

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.

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

Specialty 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 Medical Provider Administered Drug List and the Specialty Drug List that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at a Retail Pharmacy.

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

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

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

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

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

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

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

Surgery - any variety of technical procedures for treatment or diagnosis of anatomical disease or injury, such as cutting, micro Surgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, and other invasive procedures. Covered surgical services also include Anesthesia and pre- and post-operative care, including recasting.

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

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

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

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

Utilization Review - a set of formal techniques to monitor or evaluate the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, Care Management, discharge planning and/or retrospective review. Utilization Review also includes reviewing whether or not a procedure or treatment is considered Experimental or Investigational, and reviewing your medical circumstances when such a review is needed to determine if an exclusion applies.

End of Booklet