A Guide to Your Benefits

You've made a good decision in choosing
BlueAdvantage HMO and
Blue View Vision

02JA-0513

HMO Colorado

An Anthem Company

Health Plan Description Form

HMO Colorado
BlueAdvantage HMO Deductible Plan
City and County of Broomfield
Effective May 1, 2013

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Health maintenance organization (HMO)
2. OUT-OF-NETWORK CARE COVERED?[1]	Only for emergency and urgent care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the benefit booklet, 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 or use of specified providers or facilities). Consult the actual benefit booklet to determine the exact terms and conditions of coverage. Coinsurance and copayments options reflect the amount the covered person will pay.

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4. DEDUCTIBLE TYPE [2]	Calendar Year
4a. ANNUAL DEDUCTIBLE[2a] a) Individual[2b]	$500 plan deductible plus separate $100 pharmacy deductible for outpatient retail and/or mail service pharmacy drugs for tier 2 and tier 3 pharmacy drugs
b) Family[2c]	$1,500 aggregate plan deductible, plus separate $100 pharmacy deductible for outpatient retail and/or mail service pharmacy drugs for tier 2 and tier 3 pharmacy drugs per person Some covered services have a maximum benefit of days or visits allowed during a calendar year. 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.
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] a) Individual	$1,500 excludes copayments and deductibles
b) Family	$4,500 aggregate, excludes copayments and deductibles
c) Is deductible included in the out-of-pocket maximum?	No Some covered services have a maximum numbers of days or visits allowed during a calendar year. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied.

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

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum for most covered services. Infertility diagnostic services are covered. Bariatric surgery has a per occurrence maximum payment of $15,000 per member for services received from a designated facility or a per occurrence maximum benefit of $1,500 from a facility that it not a designated facility.
7A. COVERED PROVIDERS	HMO Colorado managed care network. See provider directory for complete list of current providers.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes
8. MEDICAL OFFICE VISITS[4] a) Primary Care Providers (PCP) and all OB/GYN Providers	$25 copayment per office visit. Covered person pays 10% after plan deductible for all other services (e.g. prescription drugs administered as part of an office visit and office surgeries).
b) Specialists	$40 copayment per office visit. Covered person pays 10% after plan deductible for all other services (e.g. prescription drugs administered as part of an office visit and office surgeries). While an OB/GYN is a specialist, they will be subject to the PCP copayment.
9. PREVENTIVE CARE	No copayment (100% covered) Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations, contraceptives and office visits.
10. MATERNITY a) Prenatal care	100% following a $25 copayment for the first prenatal office visit, then covered person pays 10% after plan deductible for remaining prenatal care
b) Delivery & inpatient well baby care[5] (facility and physician services)	Covered person pays 10% after plan deductible
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions[6] a) Inpatient care	Covered person pays 10% after plan deductible
b) Outpatient care	For outpatient retail and/or mail service pharmacy drugs before coverage is provided each covered person must satisfy a $100 pharmacy deductible per calendar year for tier 2 and tier 3 pharmacy drugs. Retail Pharmacy Drugs - Tier 1 $10 copayment, tier 2 $40 copayment, tier 3 $60 copayment, tier 4 20% copayment, per prescription at a participating pharmacy up to a 30-day supply. For tier 4 retail pharmacy drugs, the maximum copayment per prescription is $150 per 30-day supply. Specialty Pharmacy Drugs - Tier 1 $10 copayment, tier 2 $40 copayment, tier 3 $60 copayment, tier 4 20% 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 $150 per 30-day supply from our Specialty Pharmacy. The maximum number of copayments for a 90-day supply for an approved Specialty Pharmacy Drug is two (2). Specialty Pharmacy Drugs are not available at a retail pharmacy or from a mail-order pharmacy.
c) Prescription Mail Service	Mail-Order Pharmacy Drugs - Tier 1 $10 copayment, tier 2 $80 copayment, tier 3 $120 copayment, tier 4 20% copayment, per prescription through the mail-order service up to a 90-day supply. For the tier 4 mail-order drugs, the maximum copayment per prescription is $150 per 30-day supply or $300 per 90-day supply. Specialty pharmacy drugs are not available through the mail-order service.

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
	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 Anthem In addition to the cost sharing described above, if you purchase a tier 2, tier 3 or tier 4 prescription drug when there is a FDA rated equivalent tier 1 drug available, you are responsible for the tier 2, tier 3 or tier 4 copayment for the prescription drug and you will pay the difference between the cost of the prescription drug and the cost of the tier 2, tier 3 or tier 4 prescription drug. For example: a tier 2 prescription costs $50; a tier 1 substitution is available, the tier 1 prescription costs $20, you pay the $30 difference plus the tier 2 copayment not to exceed the negotiated rate of the drug. The $30 difference is not applied towards any other cost-sharing requirement. For drugs on our approved list, call customer service at 800-542-9402.
12. INPATIENT HOSPITAL/INPATIENT SURGERY (including laboratory/x-ray)	Covered person pays 10% after plan deductible
13. OUTPATIENT/AMBULATORY SURGERY (including laboratory/x-ray)	Covered person pays 10% after plan deductible. Colonoscopies performed for a preventive or medical purpose are not subject to the plan deductible or coinsurance (100% covered).
14. OUTPATIENT LABORATORY AND X-RAY a) Laboratory & x-ray (Includes mammograms, PAP, Prostate and Colonoscopy Testing – diagnostic or preventive)	No copayment (100% covered), deductible waived, unless otherwise noted.
b) MRI, nuclear medicine, and other high-tech services	Covered person pays 10% after plan deductible
15. EMERGENCY CARE [7] (including laboratory/x-ray)	$150 copayment per emergency room visit, then covered person pays 10% after plan deductible for all covered services which includes but is not limited to laboratory and x-ray services, medical supplies and surgery services. Care is covered in-network or out-of-network. Copayment is waived if admitted however the deductible and coinsurance will still apply.
16. AMBULANCE	$100 copayment per trip. Care is covered in-network or out-of-network.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE (including laboratory/x-ray)	$40 copayment per urgent care visit. Urgent care may be received from your PCP or from an urgent care center. Care is covered in-network or out-of-network.
18. MENTAL HEALTH CARE a) Inpatient care	Covered person pays 10% after plan deductible
b) Outpatient care Facility Care	No copayment (100% covered)
Outpatient Visits and Professional Services	$25 copayment per visit
19. ALCOHOL & SUBSTANCE ABUSE a) Inpatient care	Covered person pays 10% after plan deductible
b) Outpatient care Facility Care	No copayment (100% covered)
Outpatient Visits and Professional Services	$25 copayment per visit
20. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY a) Inpatient	Covered person pays 10% after plan deductible. Limited to 30 non-acute inpatient days per calendar year.
b) Outpatient	$25 copayment per visit Limited to 60 visits combined per calendar year for physical, occupational and speech therapy. From birth until the third birthday benefits are provided as required by applicable law.
21. DURABLE MEDICAL EQUIPMENT	Covered person pays 10% after plan deductible.
22. OXYGEN	Covered person pays 10% after plan deductible.

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
23. ORGAN TRANSPLANTS a) Inpatient b) Outpatient	 Covered person pays 10% after plan deductible $25 copayment per visit for PCP and OB/GYN Providers $40 copayment per visit for Specialists 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.
24. HOME HEALTH CARE (including laboratory/x-ray)	Covered person pays 10% after plan deductible. Limited to 100 visits per calendar year.
25. HOSPICE CARE (including laboratory/x-ray)	Covered person pays 10% after plan deductible
26. SKILLED NURSING FACILITY CARE (including laboratory/x-ray)	Covered person pays 10% after plan deductible. Limited to 100 days per calendar year.
27. DENTAL CARE	Not covered
28. VISION CARE	Vision care benefits are provided under separate vision coverage and have a $20 copayment, annual exam only. Additional information on your vision benefits included in this plan can be found on the separate Anthem Vision Summary Description.
29. CHIROPRACTIC CARE	$40 copayment per visit. Limited to 20 visits per calendar year combined with massage therapy which accumulates toward the 20 maximum visits.
30. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	 Acupuncture $40 copayment per visit. Limited to 20 visits per calendar year. Osteopathic Manipulative Therapy (OMT) $40 copayment per visit. Limited to 20 visits per calendar year. Nutritional Therapy $40 copayment per visit. Limited to 4 visits per calendar year. 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. Second Surgical Opinion Covered persons who desire another professional opinion may obtain a second surgical opinion subject to the plan deductible and 10% coinsurance.

PART C: LIMITATIONS AND EXCLUSIONS

31. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.	Not applicable; Plan does not impose limitation periods for pre-existing conditions.
32. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the benefit booklet?	No
33. HOW DOES THE BENEFIT BOOKLET DEFINE A "PRE-EXISTING CONDITION"?	Not applicable; Plan does not exclude coverage for pre-existing conditions.
34. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS BENEFIT BOOKLET?	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 benefit booklet.

PART D: USING THE PLAN

	IN-NETWORK
35. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No
36. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who scheduled the procedure or hospital care is responsible for obtaining the preauthorization. Preauthorization is also required for some tests and other services. Please consult your benefit booklet for details.
37. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
38. What is the main customer service number?	800-542-9402
39. Whom do I write/call if I have a complaint or want to file a grievance?	HMO Colorado, Complaints and Appeals 700 Broadway Denver, CO 80273 800-542-9402
40. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Broomfield Human Resources Attention: Director of Human Resources One DesCombes Drive Broomfield, CO 80020
41. To assist in filing a grievance, indicate the form number of this plan; whether it is individual, small group, or large group; and if it is a short-term policy.	Plan form #'s COLGBA Group – Large

[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 plan's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or Per Confinement".

[2a] "Deductible" or "Deductibles" 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.

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

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified plan and it may be an aggregated amount (e.g., "$1,500 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family").

[3] "Out-of-pocket maximum" Means the maximum amount you will have to pay for allowable covered expenses under a health plan, which do not include the deductibles or copayments.

[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 deductible and out-of-pocket annual maximum applies to mother and well-baby together: there are not separate deductibles and out-of-pocket maximums for mother and well-baby.

[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.

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Blue View Vision Summary of Benefits

Benefits/Plan Coverage	Network Providers	Non-Network Reimbursement Schedule**
Vision Examination: Covered up to a comprehensive level exam with dilation as necessary. **Availability : Once every calendar year**	**$20 Copayment**	**Up to $35**
Value Added Savings Materials: Blue View Vision Network Providers offer you discount pricing, which is significantly below retail for prescription lenses, frames and contact lenses. You receive substantial savings (15%-40% or more) on most eyewear purchases, conventional contact lenses, lens treatments and various sundry items.		
** Non-Network Reimbursement represents Plan's allowance towards eligible benefits and may not cover all charges.		

Limitations and Exclusions:

This is a primary vision care benefit and is intended to cover only eye examinations. Materials and other items not covered may be purchased with our Additional Savings Program from a Blue View Vision Network Provider. In addition, benefits are payable only for expenses incurred while the Group and individual Member coverage is in force. The following services are not covered:

- Eyeglass Frames
- Eyeglass Lenses
- Elective or Non-Elective Contact Lenses
- Orthoptics or vision training and any supplemental testing
- Plano (non- prescription) lenses
- Medical or surgical treatment of the eyes under the Vision rider; however, may be covered subject to plan provisions under the medical coverage
- An eye exam or corrective eyewear required by an employer as a condition of employment
- Any injury or illness covered under Workers' Compensation or similar law, or which is work related
- Sub-normal vision aids
- Plain or prescription sunglasses or tinted lenses, and no-line bifocals and blended lenses
- Charges in excess of Usual and Customary for services and material
- Experimental or non-conventional treatments or devices
- Safety eyewear
- In conjunction with other offers or discounts
- Spectacle lens styles, materials, treatments or "add-ons" not shown in the Summary of Vision Benefits.

Welcome

Welcome to HMO Colorado, where our mission is to improve the health of the people We serve. You have enrolled in a quality self-funded health benefit Plan ("Plan") that, pursuant to the terms of this Benefit Booklet, pays for many of your health care expenses, including most expenses for Physician and outpatient care, Emergency Care and Hospital inpatient care.

Important: This is <u>not</u> an insured benefit Plan. *The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by the Employer who is responsible for their payment. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.*

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

For questions about how benefits are administered, please visit Our website or call Our customer service department. The website address and local and toll-free customer service department numbers are located on your *Health Plan Description Form* or Health Benefit ID Card.

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

Mike Ramseier
President and General Manager
HMO Colorado

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

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

Health benefit coverage is defined in the following documents:

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

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

- The Employer Master Application
- The Employer Master Contract or Administrative Services Agreement between Us and the Employer

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

Additional Benefits, Away from Home Care

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

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

Short Trips

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

- For Emergency Care, call 911 or go directly to the nearest Hospital. Notify HMO Colorado within 24 hours of treatment or admission or as soon as reasonably possible.
- For non-Emergency Care, call your PCP or HMO Colorado for Preauthorization. The Preauthorization phone number is on the back of your Health Benefit ID Card.
- To find the names and addresses of nearby doctors and Hospitals, visit the BlueCard® Doctor and Hospital Finder at www.bcbs.com, or call BlueCard Access toll free at 1-800-810-BLUE.
- When you arrive at the participating doctor's office or Hospital, simply present your Health Benefit ID Card.

After you receive care, you should not have to complete any claim forms or pay up front for medical services, except for the out-of-pocket expenses (non-Covered Services and Copayments) you would usually pay.

Extended Stays

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

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

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

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

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YOUR RIGHTS AND RESPONSIBILITIES

We are committed to:

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

You have the right to:

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

You have the responsibility to:

- Choose a participating Primary Care Physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor’s office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that We and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let Our customer service department know if you have any changes to your name, address, or family Members covered under your policy.
- Provide Us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with Us.

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

ABOUT YOUR HEALTH BENEFITS

This is a Health Maintenance Organization (HMO) health benefit plan. We have coordinated and contracted with a network of Physicians, Hospitals, and support services (e.g., laboratory, x-ray, and Pharmacy) to arrange for or provide comprehensive health care services to Members for a fixed payment. Learning how an HMO works can help you make the best use of your health care benefits. The *Health Plan Description Form* lists out-of-pocket expenses and certain benefit limits you may incur.

We strive to maintain reasonable health care costs by working with you, your Physicians, Hospitals, and other Providers in unity. You and your Primary Care Physician (PCP) work together to obtain care from a Specialist and to obtain Preauthorizations for services, helping to ensure that you receive care that is Medically Necessary, performed in the appropriate setting, and is otherwise a Covered Service. A result of your collaboration with your Primary Care Physician is lower cost of health care. More details can be found under the **MANAGED CARE FEATURES** heading in this section of this Benefit Booklet.

Primary Care Physicians

A key feature of an HMO is that one doctor will be primarily responsible for delivering and coordinating all of your care. That Physician is called a Primary Care Physician (PCP). PCPs are typically internal medicine Physicians, family practice Physicians, general practitioners, or pediatricians. As your first point of contact, the PCP provides a wide range of health care services, including initial diagnosis and treatment, health supervision, management of chronic conditions, and Preventive Care. You can access care from In-Network Providers without a referral (including OB/GYN care). Your PCP can provide you with information about Specialists who are In-Network.

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

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

Selecting A PCP

At the time of enrollment, you must select a PCP. Family Members are not required to choose the same PCP; they may select a PCP individually. If a PCP is not chosen, We will assign one to the Member.

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

You should refer to Our website at www.anthem.com for a list of PCPs or call Our customer service department for a Provider directory. Our website is continuously updated and is the most up-to-date list of Our PCPs. Some Providers are listed as accepting existing patients only. However, We may not have notice of new limitations of this kind. Therefore, even if the listing for the PCP you select does not indicate patient limitations, you should call the PCP to confirm that the Provider is still accepting new patients (unless you are already an existing patient of the PCP).

Visiting A PCP

To visit a PCP, you must make an appointment with the PCP's office. The telephone number for the PCP can be found on your Health Benefit ID Card. To avoid possible delays when scheduling an office visit over the phone, you must identify yourself as an HMO Colorado Member. The PCP's office will instruct you on next steps in non-Emergency Care or non-Urgent Care situations.

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

After hours care is provided by your Physician who may have a variety of ways of addressing your needs. You should call your PCP for instructions on how to receive medical care after the PCP's normal business hours, on weekends and holidays, or to receive non-Emergency Care and non-Urgent Care within the Service Area for a condition that is not life threatening but that requires prompt medical attention. In case of an Emergency, you should call 911 or go directly to the nearest Emergency room. If you are outside the Service Area, non-Emergency Covered Service may be covered under the BlueCard Program. More information about the BlueCard® program can be found on the page entitled *Additional Benefits, Away from Home Care* located in the front of this Benefit Booklet.

Changing PCPs

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

The Effective Date of all PCP changes will be the first day of the month following requests which are made by the 25th of the month. To have medical records transferred from one PCP to another, you must contact your former PCP. You are responsible for any fees related to transferring medical records.

Care Outside of Colorado

When you are outside Our Service Area for extended periods of time, care is available through the BlueCard® Program or through the Guest Membership benefit. Details on the away from home care programs can be found in the front of this Benefit Booklet under the heading entitled *Additional Benefits, Away From Home Care.*

Cost Sharing Requirements

Cost Sharing refers to how We, on behalf of the Employer and its Members, share the cost of health care services with you. It defines what We, on behalf of the Employer, are responsible for paying and what you are responsible for paying. You satisfy the Cost Sharing requirements through the payment of Copayments, Deductible and Coinsurance (as described below and in the *Health Plan Description Form*) depending upon the terms of your benefits.

The contracts between Us and Our In-Network Providers include a "hold harmless" clause which provides that you cannot be liable to the In-Network Provider for money owed by Us for health care services provided under this Benefit Booklet.

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

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

Maximum Allowed Amount

This section describes how We determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by HMO In-Network Providers is based on your Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see the BlueCard Program as described in the **ADMINISTRATIVE SERVICES** section under **How to File Claims** for additional 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 the terms of this Certificate and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Preauthorization, Utilization Management or other requirements set forth in this Certificate.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you 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 occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

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

Member Cost Share

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

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

Copayment

Copayments are your Cost Sharing requirements under this coverage. A Copayment is a predetermined, fixed-dollar amount you must pay to receive a specific Covered Service. You are required to pay a Copayment to In-Network Providers for specific Covered Services as listed in the *Health Plan Description Form*. You are responsible for making Copayments directly to the In-Network Provider. You must pay fixed-dollar Copayment amounts even after meeting Deductible or Coinsurance requirements. Copayment amounts do not apply to Deductible and/or Coinsurance requirements.

Services from Out-of-Network Providers are covered only under limited circumstances. Non-Emergency services from Out-of-Network Providers are **not covered** unless specifically authorized by Us **before** services are received. If We have Preauthorized the Member to seek Covered Services from an Out-of-Network Provider, We will apply the In-Network level of benefits and the Member will not be required to pay more for the services than if the services has been received from a HMO In-Network Provider.

Deductible

A Deductible is a specified dollar amount for Covered Services that you must pay within your Benefit Period before We provide benefits. Deductibles do not contribute toward your Out-of-Pocket Annual Maximum. The Deductible amount is listed in the *Health Plan Description Form* included at the front of this Benefit Booklet. If a service is subject to a Copayment, that service is not subject to the Deductible, except that services for Emergency Care are subject to a Copayment, Calendar Year Deductible and Coinsurance. Each Member must meet a separate Deductible. A new Deductible is required for each Benefit Period.

There is a separate annual front-end Deductible per Member for Tier 2 and 3 Prescription Drugs (retail and mail order combined). Once this separate prescription drug annual Deductible has been satisfied, Copayments will apply as described in the *Health Plan Description Form.*

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

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

Coinsurance/Out-of-Pocket Annual Maximum

The Out-of-Pocket Annual Maximum is designed to protect you from catastrophic health care expenses. You must first meet your required Benefit Period Deductible. After the Deductible is met, We pay a percentage of charges for Covered Services as listed on the *Health Plan Description Form*. This percentage is called Coinsurance. For some services, you must also pay your required Copayment.

You pay Coinsurance for Covered Services until the Out-of-Pocket Annual Maximum is reached for your Benefit Period. Until the Out-of-Pocket Annual Maximum is reached, you pay the remaining percentage. Once the Out-of-Pocket Annual Maximum is reached, We pay 100 percent of any remaining eligible charges for the remainder of your Benefit Period. Copayments are still required even when you have satisfied the Out-of-Pocket Annual Maximum.

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

When no family Member meets one-third of the family Out-of-Pocket Annual Maximum, but the family Members collectively meets the entire family Out-of-Pocket Annual Maximum, then all family Members will be eligible for benefits.

Benefit Period Maximum

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

Managed Care Features

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

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

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

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

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

Transition of Care

A new Member to this coverage may be receiving ongoing care for a medical condition. Examples of ongoing care include prenatal/obstetrical care, Home Care or Hospice Care. We strive to avoid disruption of a new Member’s care through Our transition of care policy. To facilitate the transition of care, you or your Provider must review the reference sheet, complete a Transition of Care Form and submit them to Us for review. You or your Provider may request a

reference sheet and Transition of Care Form by calling Our medical management department at 303-831-3238 or 1-800-797-7758.

Our Process to Determine If Services are Covered

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

In administering benefits on behalf of the Employer, We determine whether services, procedures, supplies or visits are Medically Necessary. Only Medically Necessary services (except as otherwise provided in this Benefit Booklet), procedures, supplies or visits are Covered Services. We use medical policy, medical practice guidelines, professional standards and outside medical peer review to determine Medical Necessity. Our medical policy reflects current standards of practice and evaluates medical equipment, treatment and interventions according to an evidence-based review of scientific literature. Medical technology is constantly changing, and We reserve the right to periodically review and update Our medical policies using evaluations of national medical associations, consensus panels and other technology evaluation bodies. The benefits, exclusions and limitations of this Benefit Booklet take precedence over medical policy.

Certain procedures, diagnostic tests, Durable Medical Equipment, Home Care Services, Home Intravenous services and medications require Preauthorization. The current list of services requiring Preauthorization is available on Our website. It is the Provider's responsibility to Preauthorize the test, equipment, service or procedure. See the **Appropriate Place and Preauthorization** section for additional details.

Experimental/Investigational and/or Cosmetic Procedures – In administering benefits on behalf of the Employer, We will not pay for any services, procedures, surgeries or supplies that We consider Experimental/Investigational and/or cosmetic. Additionally We will not pay for complications arising from any services, procedures, surgeries or supplies that We consider Experimental/Investigational and/or cosmetic.

Appropriate Place and Preauthorization

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

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

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

The In-Network Provider who schedules an admission or orders the procedures or service is responsible for obtaining Preauthorization. To determine which drugs and/or services require Preauthorization and/or to be sure that Preauthorization has been obtained, you may contact Us.

Inpatient Admissions - Admissions for all inpatient stays require Preauthorization and concurrent reviews. Your In-Network 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 the Member's Benefit Booklet are provided. We initially authorize a specified number of days for the inpatient stay and reevaluate such Authorization if additional days are requested by the In-Network Provider. This process facilitates your timely discharge or transfer to the appropriate level of care.

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

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

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

Inpatient admissions include admissions to acute care facilities (Hospitals), long-term care facilities, sub-acute facilities, rehabilitation facilities, Skilled Nursing Care Facilities and inpatient Hospice Facilities.

Outpatient Procedures - Many procedures performed on an outpatient basis must be Preauthorized. Your Provider must contact Us for Preauthorization. You and Providers may visit Our website at www.anthem.com or call Our customer service department for a list of outpatient procedures and services that require Preauthorization. These services may be performed in a Hospital on an outpatient basis or in a freestanding facility, such as an Ambulatory Surgery Center.

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

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

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

You or your representative may appeal Our Preauthorization decision by following the procedure outlined in the **COMPLAINTS, APPEALS AND GRIEVANCES** section of this Benefit Booklet.

Appropriate Length of Stay

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

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

At some point during hospitalization, We may determine that further hospitalization is not Medically Necessary. We will advise your attending Physician and the Hospital of this determination. You may elect to remain in the Hospital after you have been notified that continued hospitalization is not Medically Necessary, but We will not pay for services after

the recommended date of discharge. We will also send written notification of the decision to you, the attending Physician and the Hospital. **You will be responsible for all charges incurred after the recommended date of discharge.**

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

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

Ongoing Care Needs

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

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

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

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

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

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

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

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

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

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

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

EMPLOYEE AUDIT OF MEDICAL BILL

The Employer will pay a cash bonus to any Subscriber who brings to the attention of the Employer that an overpayment occurred as the result of either:

- A service Provider (Hospital, Physician, etc.) overcharging $50 or more to the Plan; or
- Errors in claims processing.

In order to receive the bonus, the Subscriber must obtain and send a corrected bill and the original incorrect bill to the Employer. In the case of claims processing errors, a copy of the correct bill and the Explanation of Benefits from Us must be submitted. The bonus equals 50% of the savings up to a maximum bonus of $1,000. Any tax liability associated with the bonus is the responsibility of the Subscriber.

This provision is subject to the terms as set forth by the Employer and is the responsibility of the Employer and not Us.

SPECIAL SERVICES

Certain services are payable at the In-Network level even when not performed by a Network Provider. These services include:

- Services (other than surgical assistance) of a Non-Participating Provider such as, but not limited to:
  - inpatient consultations, neonatology, x-rays and lab tests, radiology, anesthesiology and other Specialists over whom you have no control in selecting after admission, when you are admitted for inpatient or outpatient care in a Network Facility, if the admission and the Provider's services are approved by Us; or an Out-of-Network facility, if the admission and the Provider's services are approved by Us, and the Authorization indicates that the services are payable at the In-Network level.
- Services of an Out-of-Network assistant surgeon, Surgical Assistant or any other Out-of-Network Provider who is qualified to assist during Surgery (other than Surgery performed as part of Emergency Room Care), if the Surgery is performed by an In-Network Provider in an In-Network Facility. The use of an assistant during Surgery must be appropriate for the type of Surgery rendered.
- Inpatient care provided in an Out-of-Network Hospital or by an Out-of-Network Provider immediately following Emergency Care through stabilization if the services are approved by Us.
- Ambulance services and Emergency Care.
- Services of an Out-of-Network radiologist or pathologist when services are performed by an In-network Provider or an In-Network facility.

MEMBERSHIP

Subscriber

The Subscriber is an enrolled full-time employee or enrolled COBRA participant in whose name the membership is established.

A full-time employee is hired to work in a continual, year-round position for a minimum of 2,080 hours in a calendar year (or proportionally less for an employee hired during the calendar year). Part-time and temporary employees are not eligible.

Dependents

The Employer will require documentation at time of enrollment (including new enrollment, annual open enrollment and special enrollment) to verify dependent status. Examples of documents which must establish a dependent relationship include, but are not limited to:

- Marriage certificate
- Birth Certificate
- Legal documents that establish guardianship
- Adoption papers
- Other documentation which the Employer deems sufficient to prove dependent status

If an employee is unable to provide acceptable documentation to establish dependent status, enrollment for the dependent(s) will be denied.

A Subscriber's Dependents may include the following:

- **Legal spouse**, as recognized under the laws of the state where the Subscriber lives.
- **Common-law Spouse**. The Subscriber must submit a Common-Law Marriage Affidavit for the common-law Spouse to be considered for enrollment. The Common-Law Marriage Affidavit may be obtained through the Employer or by calling Our customer service department. Common-law marriage if based on Colorado state law is valid for all purposes the same as a ceremonial marriage. All references to Spouse in this Benefit Booklet include a Common-Law Spouse.
- **Same 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 your same sex domestic partner will be eligible. All references to Spouse in this Benefit Booklet include a same sex domestic partner.
- **Newborn child**. A newborn child born to the Subscriber or Subscriber's Spouse is covered under the Subscriber's coverage for the first 31 days after birth. If the mother of the newborn child is a Dependent child of the Subscriber, the newborn is **not** covered (see the **Grandchild** heading in this section).

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

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

Subscribers not enrolled for Dependent coverage who complete an Enrollment Application to add a newborn or adopted child within 31 days of birth or placement for adoption will be required to pay Dependent Premium due the first of the month following birth or placement for adoption. However, coverage on this child will become effective on the date of birth or placement for adoption. Any other eligible Dependents who are also enrolled as a result of this event will become effective for coverage on the first of the month following the date of birth of the newborn or placement for adoption on a child, rather than the date of the event.

The requirement to add a newly acquired Dependent (by birth or adoption) within 31 days is not enforced for Subscribers who are already enrolled in and paying for Dependent coverage. Newly acquired Dependents in this case are automatically covered, but a form should be completed notifying Us of the newly acquired Dependent's name and birth date.

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

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

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

  Subscribers not enrolled for Dependent coverage who complete an Enrollment Application to add a newborn or adopted child within 31 days of birth or placement for adoption will be required to pay Dependent Premium due the first of the month following birth or placement for adoption. However, coverage on this child will become effective on the date of birth or placement for adoption. Any other eligible Dependents who are also enrolled as a result of this event will become effective for coverage on the first of the month following the date of birth of the newborn or placement for adoption on a child, rather than the date of the event.

  The requirement to add a newly acquired Dependent (by birth or adoption) within 31 days is not enforced for Subscribers who are already enrolled in and paying for Dependent coverage. Newly acquired Dependents in this case are automatically covered, but a form should be completed notifying Us of the newly acquired Dependent's name and birth date.

- **Dependent child**. A child (including a stepchild or a disabled child) under 26 years of age may be covered under the terms of this Benefit Booklet. At the end of the birth month in which the child turns age 26, the Dependent child is removed from coverage. If the Subscriber or the Subscriber's Spouse is subject to a qualified medical child support order for a Dependent child of the Subscriber or the Subscriber's Spouse, the Dependent child is eligible for coverage, whether the child lives with the Subscriber or the Subscriber's Spouse. The dependents (spouse or child) of a Dependent child are not eligible for coverage under this Benefit Booklet.

- **Disabled Dependent child**. An unmarried child who is 26 years of age or older, medically certified as disabled, and dependent on the Subscriber or the Subscriber's Spouse may be covered under the terms of this Benefit Booklet. We must receive notice of the disability for the disabled Dependent's coverage to continue after the Dependent child turns age 26. The Subscriber and the disabled Dependent's Physician must complete and submit a Mentally or Physically Disabled Dependent Form to Us. You may call Our customer service department or go to Our website to obtain a Mentally or Physically Disabled Dependent Form.

- **Grandchild**. A grandchild of a Subscriber or a Subscriber's Spouse is not eligible for coverage unless the Subscriber or the Subscriber's Spouse is the grandchild's court-appointed permanent guardian or has adopted the grandchild. The Subscriber must submit an Enrollment Application and Change Form and evidence of court appointment as permanent guardian or documents evidencing a legal adoption.

Medicare-Eligible Members

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

If you qualify under the provisions of federal law for the working aged, then you, if age 65 or older, may continue benefits under this Plan. If a working aged eligible Medicare beneficiary enrolls with Medicare and requests Medicare as primary coverage, coverage under this Benefit Booklet ends for that Member. Special Medicare Secondary Payer (MSP) rules apply if you are receiving benefits from Medicare due to a disability or end-stage renal disease.

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

Enrollment Process

For eligible Subscribers and their eligible Dependents to obtain coverage, the Subscriber must enroll within 31 days of employment. Coverage becomes effective on the first of the month following or coincident with the Subscriber's date of full time employment, as defined in the MEMBERSHIP section. No services received before that date are covered.

The Employer will require documentation at time of enrollment (including new enrollment, annual open enrollment and special enrollment) to verify dependent status. Examples of documents which must establish a dependent relationship include, but are not limited to:

- Marriage certificate
- Birth Certificate
- Legal documents that establish guardianship
- Adoption papers
- Other documentation which the Employer deems sufficient to prove dependent status

If an employee is unable to provide acceptable documentation to establish dependent status, enrollment for the dependent(s) will be denied.

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

Note: You have the right to obtain a Certificate of Creditable Coverage from your prior plan. Please contact Our customer service department for assistance in obtaining such Certificate.

Enrollment Forms

The Subscriber must submit an Enrollment Application and Change Form and documentation to verify dependent status to add any Dependents as Members. Additional forms may be required for special Dependent status. Documentation to verify dependent status must be attached to the completed Enrollment Application and Change Form to add dependents. If an employee is unable to provide acceptable documentation to establish dependent status, enrollment for the dependent(s) will be denied. Subscribers may obtain an Enrollment Application and Change Form or any additional forms from your Employer.

Initial Enrollment

Eligible employees may apply for coverage for themselves and their eligible Dependents by submitting an Enrollment Application and Change Form. Documentation to verify dependent status must be attached to the completed Enrollment Application and Change Form to add dependents. If an employee is unable to provide acceptable documentation to establish dependent status, enrollment for the dependent(s) will be denied. We must receive the Enrollment Application and Change Form and supporting documentation within 31 days after the date of hire.

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

Open Enrollment

Any eligible employee who did not enroll when initially eligible, as a newly eligible Dependent or during a special enrollment may enroll during the Employer's annual Open Enrollment period. Documentation to verify dependent status must be provided to the Employer to add dependents. If an employee is unable to provide acceptable documentation to establish dependent status, enrollment for the dependent(s) will be denied. The Employer's benefit coordinator will provide the Open Enrollment period date and the Anniversary Date to the eligible employee.

Newly Eligible Dependent Enrollment

A current Subscriber of this coverage may add a Dependent who becomes newly eligible due to a qualifying event. Qualifying events include marriage, birth, placement for adoption or issuance of a court order. We must receive an Enrollment Application and Change Form for the addition of the Dependent within 31 days after the date of the qualifying event. Proof of the qualifying event, e.g., a copy of the marriage certificate or court order, must be attached to the completed Enrollment Application and Change Form. Documentation to verify dependent status must be attached to the completed Enrollment Application and Change Form to add dependents. If an employee is unable to provide acceptable documentation to establish dependent status, enrollment for the dependent(s) will be denied. For the purposes of Common-Law marriage, the date of the qualifying event will be the date of the marriage. Coverage will be effective on the date of the qualifying event.

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

Special Enrollment for Eligible Employees and Eligible Dependents

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

Family Status Change - Qualifying events for special enrollment due to a family status change include marriage, divorce, birth, placement for adoption or the issuance of a qualified medical child support order. Coverage with Us will be effective on the date of the qualifying event. However, when other eligible Dependents (such as siblings of a newborn) are enrolled as a result of a Family Status Change, benefits under this Plan will be effective on the first of the month following the date of the qualifying event. When the qualifying event is a birth, and the mother is not previously enrolled, any charges related to labor and delivery due to the birth are not covered. We must receive the completed Enrollment Application and Change Form within 31 days after the date of the qualifying event. Proof of the qualifying event, e.g., a copy of the marriage certificate or court order, must be attached to the completed Enrollment Application and Change Form. Documentation to verify dependent status must be attached to the completed Enrollment Application and Change Form to add dependents. If an employee is unable to provide acceptable documentation to establish dependent status, enrollment for the dependent(s) will be denied.

Involuntary Loss of Coverage – For the eligible employee and/or eligible Dependent to qualify for special enrollment due to involuntary loss of the other group health insurance coverage, the loss of coverage must be due to termination of employment, reduction in the number of hours of employment, involuntary termination of Creditable Coverage, death of the Subscriber, legal separation or divorce, cessation of Dependent status, the other plan no longer offering any benefits to the class of individuals, or the termination of employer contributions toward the coverage. If the other coverage does not provide benefits to individuals who no longer reside, live or work in a Service Area, and no other benefit package is available, loss of coverage because an individual (voluntarily or involuntarily) no longer resides, works or lives in the Service Area will be considered an involuntary loss of coverage. If the employee is approved for special enrollment, the benefits with Us will be effective on the day following the loss of other coverage. Documentation to verify dependent status must be attached to the completed Enrollment Application and Change Form to add dependents. If an employee is unable to provide acceptable documentation to establish dependent status,

enrollment for the dependent(s) will be denied. If COBRA or state continuation coverage is available, enrollment may only be requested after exhausting the COBRA or state continuation coverage.

If the eligible employee and/or the eligible Dependents had health insurance coverage elsewhere and voluntarily canceled such coverage, the eligible employee and/or the eligible Dependents do not qualify for special enrollment. However, the eligible employee and/or the eligible Dependents will be allowed to enroll at the Employer's annual Open Enrollment.

Status Change of State Medicaid Plan or State Child Health Insurance Program (SCHIP) - Loss of eligibility from a state Medicaid or SCHIP health plan is also a qualifying event for special enrollment for the eligible employee and/or eligible Dependents. The employee must properly file an application with the Employer within 60 days after coverage has ended. In addition, special enrollment is allowed for the employee who becomes eligible for premium assistance, with respect to coverage under the Employer's health coverage, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. Similarly, the employee must properly file an application with the Employer within 60 days after the eligibility date for assistance is determined.

Documentation to verify dependent status must be attached to the completed Enrollment Application and Change Form to add dependents. If an employee is unable to provide acceptable documentation to establish dependent status, enrollment for the dependent(s) will be denied.

Military Service

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

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

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

How to Change Coverage

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

Termination

Active Policy Termination

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

- On the date the Employer Master Contract between the Employer and Us is terminated.
- Upon the Subscriber's death.
- When the required Premium has not been paid.
- When you or your Employer commits fraud or intentional misrepresentation of material fact.
- The end of the month in which you are no longer eligible for coverage under the terms of the Employer Master Contract.

- When you are deemed a "working aged," as defined by federal law, and you choose to have Medicare become your primary coverage.
- When the Subscriber's Employer gives Us written notice that the Subscriber is no longer eligible for coverage. Coverage will be terminated 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 written notification to cancel coverage for any Member, benefits will end at the end of the month of the qualifying event.
- When you move and therefore neither reside nor work within the Service Area unless you are continuing coverage under COBRA continuation, you must notify Us within 31 days of such a change in location. Coverage will end on the last day of the month in which the change of residence is reported; until that time, the only out-of-area services covered will be Emergency Care and Urgent Care. Non-Emergency Care will not be covered.
- If you do not notify Us of a change of residence or workplace to an area outside Our Service Area, and We later become aware of the change, your coverage may be retroactively terminated to the date of the change of residence or place of employment. You will be liable to Us and/or the Providers for payment for any services covered in error.
- When We cease operations.

Dependent Coverage Termination

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

We will credit subscription charges paid in advance on behalf of the terminated Dependent unless We do not receive the Enrollment Application and Change Form prior to the Effective Date of the change or if We have paid any claims on behalf of the terminated Dependent in the period for which the credit would otherwise be owed to the Employer.

Benefits for a Dependent end on the last day of the month in which any of the following events occur:

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

Certificate of Creditable Coverage

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

What We Will Pay for After Termination

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

Continuation of Coverage

Family and Medical Leave Act

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

COBRA Eligibility and Notification

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

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

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

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

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

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

- The surviving Spouse and surviving children of a covered employee, when the covered employee dies.
- Spouse and Dependent children of covered employee, if the employee became eligible for Medicare benefits before COBRA election. However, the maximum time period will begin when the employee became entitled to Medicare or 36 months, whichever is greater.
- Spouses and Dependent children of a covered employee, when the employee and the Spouse separate or divorce.
- Dependent children of the covered employee, when the Dependent children lose eligibility as Dependents.

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

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

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

Termination of COBRA

Your continuation coverage terminates when the continuation period is exhausted. The duration of continuation coverage is detailed under the “COBRA Eligibility” heading in this action.

Continuation coverage may terminate before the continuation period expires if:

- The Employer Master Contract or Administrative Services Agreement between the Employer and Us is terminated. If the Employer selects a replacement group coverage, continuation coverage will continue under the new coverage.
- You fail to pay required fees or Premium in a timely manner.

- After electing COBRA coverage, you become covered by another group health insurance policy unless the other coverage excludes a condition covered by the COBRA coverage; in that case, the COBRA coverage continues until exhausted or the other coverage covers the excluded condition.
- After electing COBRA coverage, you become covered by Medicare. However, any eligible covered Dependents will be entitled to continue COBRA coverage for a maximum of 36 months from the original COBRA date.
- Your COBRA coverage was extended to 29 months and you are determined under the Social Security Act to no longer be disabled.
- You submit written notice of voluntary cancellation of coverage.

Conversion

When COBRA coverage is exhausted, Subscribers and their eligible Dependents who were covered under a group's health insurance policy may apply for conversion coverage. In addition, when a Dependent (other than a Spouse), loses his or her status as a Dependent under this Benefit Booklet (e.g. reaching age constraints), he or she may be eligible for conversion coverage, subject to the terms below. In the event that COBRA coverage is not available, the Subscriber and eligible Dependents must have been covered under the group coverage for at least three months immediately before the termination of group coverage to be eligible for this conversion coverage. **The conversion coverage must be the same type of coverage** as was terminated with Us as the Subscriber's prior coverage under the group policy, and it must be with one of Our Basic or Standard Plans. Conversion coverage is not available if the group health coverage has been discontinued in its entirety. Conversion coverage through Us is not available if the election period occurs after the group has replaced this coverage.

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

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

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

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

COVERED SERVICES

This section describes Covered Services available under your health care benefits when provided by an In-Network Provider or as authorized by Us. Covered Services and supplies are only benefits if they are Medically Necessary or preventive, not otherwise excluded under this Benefit Booklet as determined by Us and obtained in the manner required by this Benefit Booklet. You must obtain care by or through your PCP or another In-Network Provider to be a Covered Service except as provided by this Benefit Booklet. Additionally, all services must be standard medical practice where they are received for the illness, injury or condition being treated, and must be legal in the United States. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment by Us.

A PCP provides you with basic health services and other medical services. Sometimes the PCP determines that it is necessary, or you request, to see a Specialist or other Provider. If you use an Out-of-Network Provider, your claim will be denied unless services were for Emergency or Urgent Care, or Preauthorized by Us.

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

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

Preventive Care Services

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

Preventive Care services include Outpatient services and Physician Office services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service, with the exception of the Covered Services listed under #4 below.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Physician Office Services or Diagnostic Services benefits.

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

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:

- Breast cancer;
- Cervical cancer;
- Colorectal cancer;
- High Blood Pressure
- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child and Adult Obesity.

2. Immunizations (including those required for school and travel)

3. Preventive Care and screenings for children, adolescents, and adults as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. This includes Child Health Supervision Services (including limited smoking cessation services) for Dependent children up to age 13, but only to the extent coverage is required by applicable insurance law.

- Other preventive care and screening for women are also covered based on the guidelines from the Health Resources and Services Administration, including the following:
  - Women's contraceptives, sterilization procedures, and counseling. This includes Generic and Single Source Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants are also covered. You must get covered contraceptives from an In-Network pharmacy or participating Provider. If you don't, they will not be covered. Multi-Source Drugs will be covered under the Retail Pharmacy/Home Delivery Pharmacy Prescription Drugs below.
  - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per Benefit Period.
  - Gestational diabetes screening.

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

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

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

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

www.healthcare.gov/law/about/provisions/services/lists.html.

4. Covered Services also include the following services paid at 100% when provided by a participating Provider:
   - Routine screening or diagnostic mammograms, regardless of age or frequency;
   - Routine or diagnostic cytologic screening (pap test), regardless of frequency;
   - Routine or diagnostic prostate specific antigen (PSA) blood test and digital rectal examination, regardless of age or frequency;
   - Colon cancer screenings and related laboratory tests;
   - Routine or diagnostic colonoscopies, regardless of age or frequency and related lab 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.

Coverage for benefits in this section shall meet or exceed those required by applicable insurance law, which may change from time to time.

In addition to federal law requirements, the following services are covered:

- Annual medical diabetes eye exams, or in accordance with the frequency determined by your Provider;
- Flu shot when received from your Provider's office. If it's more convenient to get your flu shot at a flu shot clinic, you may be eligible for reimbursement of some or all of your out of pocket costs. Reimbursement for one flu shot per Benefit Period, or as determined by Us, at locations such as a flu shot clinic location. Examples of locations that may provide flu shots and may be considered flu shot clinics include your local Pharmacy, your place of employment, a grocery store, Wal-Mart, Walgreens or Costco. There may be additional flu shot clinic locations available to you. Information on the reimbursable flu shot benefit, including the claim form and reimbursement amount, are located on Our website at www.anthem.com. The claim form you need to submit for reimbursement and the reimbursement amount is available on Our website at www.anthem.com or call Our customer service department. This annual reimbursement is subject to change. Your cost for a flu shot otherwise paid for in full or in part by another party, is not eligible for reimbursement.

Infertility Services

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

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

Maternity Services and Newborn Care

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

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

The annual Deductible is waived for inpatient Physician and Hospital charges for well newborn babies who are discharged when the mother is discharged from the Hospital. A separate Deductible and Coinsurance apply to the newborn baby if the newborn does not leave the Hospital with the mother.

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

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

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

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

- parent education;
- physical assessments;
- assessment of the home support system;
- assistance and training in breast or bottle feeding; and
- performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for the mother or newborn child, including the collection of an adequate sample for the hereditary disease and metabolic newborn screening.

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

Therapeutic termination of pregnancy is a benefit only when the pregnant Member or unborn child is endangered and every reasonable effort has been made to save their lives. The procedure must be performed in a Hospital or other facility. There must be documentation of at least one of the following conditions:

The Member has a medical condition as determined by the Physician, which represents a serious threat to the life of the pregnant Member if the pregnancy is allowed to continue; or

There is a medical condition in the unborn child, as confirmed by two Physicians, which would result in the death of the unborn child during the term of the pregnancy or at birth; or

There is a psychiatric condition, which represents a serious and substantial threat to the life of the pregnant Member if the pregnancy continues. The Physician must obtain consultation form a licensed Physician specializing in psychiatry confirming the presence of such a psychiatric condition unless the pregnant Member has been receiving prolonged psychiatric care.

Diabetes Management Services

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

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

- Ordered in writing by a Physician; and
- Provided by a health care professional who is certified, registered or licensed with expertise in diabetes.

Diabetes medical nutrition Therapy Services are not subject to and do not reduce the nutritional therapy limit as listed on the *Health Plan Description Form*. A diabetes education session must be provided by a health care professional in an outpatient facility or in a Physician's office. Screenings for gestational diabetes are covered under Preventive Care Services.

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

Physician Office Services

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

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

Covered Physician office services include visits for medical care, consultations and Second Opinions to: examine, diagnose and treat an illness or injury performed in the Physician's office, including birth control. Office visits also include allergy injections and allergy serum, allergy testing and non-Urgent or non-Emergency Care. See this "Covered Services" section for more information on prescription drugs administered in the office.

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

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

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

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

Inpatient Services

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

Inpatient services do not include care related to Maternity Services and Mental Health Care, Alcohol Dependency and Substance Dependency Services, except as specified.

Inpatient services include:

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

Skilled Nursing Care Facility (SNF)

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

Inpatient Rehabilitation Therapy

Inpatient medical rehabilitation therapy benefits for Medically Necessary care for the primary purpose of restoring and/or improving lost functions following an injury or illness. Inpatient Rehabilitation Therapy may be received at an acute rehabilitation facility, Skilled Nursing Care Facility, long term acute care facility or a sub-acute facility. In the Benefit Booklet We refer to three types of Inpatient Rehabilitation Therapy: Acute Rehabilitation Therapy, Chronic Rehabilitation Therapy and Sub-Acute Rehabilitation Therapy.

Room, Board and General Nursing Services

- A room with two or more beds;
- A private room, however the allowance is the Provider's average semi-private room rate unless it is Medically Necessary that you occupy a private room for isolation and no isolation facilities are available or the facility does not have any available semi-private rooms; and
- A room in a special care unit approved by Us. The special care unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary Services

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

Professional Services

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

Outpatient Services

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

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

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

See this "Covered Services" section for more information on prescription drugs administered in the office.

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

For Dental Services refer to the **DENTAL RELATED SERVICES** section of this Benefit Booklet.

Diagnostic Services

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

Covered Services are payable at 100%, except when performed in conjunction with inpatient services, Outpatient Surgery, Home Care Services, Hospice Services and Emergency Care, in which case the Deductible and 10% Coinsurance apply. Emergency Care is also subject to a Copay.

Coverage for Diagnostic Services when provided as part of Preventive Care Services, Physician Office Services, Infertility Services, Inpatient Services, Outpatient Services, Home Care Services, Hospice Services, Emergency Care and Urgent Care include the following:

- X-ray and other radiology services;
- Laboratory and Pathology Services;
- Cardiographic, encephalographic and radioisotope tests;
- Ultrasound services;
- Allergy tests;
- Hearing tests, unless related to an examination for prescribing or fitting of a hearing aid, except as required by applicable law;
- Genetic testing when allowed by Our medical policy;
- Ultrafast CT scans when Preauthorized and allowed by Our medical policy; and
- Mammograms, Pap Tests, Prostate Exams and Testing, and Colonoscopies are covered as outlined in the *Health Plan Description Form.* These tests are allowed regardless of age or frequency and are covered whether preventive or diagnostic in nature.

Surgical Services

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

Covered Services are subject to the Deductible and 10% Coinsurance, except expenses related to colonoscopies and Surgery related to Physician Office Services, which are payable at 100%.

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

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Sterilization services;

- Anesthesia and surgical assistance as determined by our medical policy. We do not pay for all Surgical Assistant procedures. The list of procedures, which allow a Surgical Assistant or assistant surgeon, is available to your Provider;
- Colonoscopies as outlined in the *Health Plan Description Form* and in the Preventive Services section of this Benefit Booklet;
- Usual and related pre-operative and post-operative care; and
- Other procedures as approved by Us.

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

The surgical fee includes normal post-operative care.

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

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

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

Emergency Care and Urgent Care

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

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

Emergency Care

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

We cover Emergency Care necessary to screen and Stabilize you without Preauthorization if a prudent person having average knowledge of health services and medicine and acting reasonably would have believed that a medical condition or life or limb-threatening condition requiring Emergency Care existed. “Life or limb-threatening Emergency” means any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health. Necessary Emergency Care may include, but is not limited to, Diagnostic Services, Surgical Services and Medical Supplies.

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

Urgent Care

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

Urgent Care is care provided for Members who require immediate medical attention but whose condition is not life-threatening (non-Emergency). Treatment of an Urgent Care medical problem is not an Emergency and does not require use of an Emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical

problem and you are advised to go to an Emergency room, your care will be paid at the level specified in the *Health Plan Description Form* for Urgent Care.

Obtaining Emergency or Urgent Care

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

- Know the difference between an Emergency and an Urgent Care situation;
- If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. If you are experiencing an Urgent Care medical problem, go to an Urgent Care Center or your Physician's office. If there is not one nearby, then go to the Hospital;
- Call your PCP or Us within 72 hours or as soon as reasonably possible;
- Ask if the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan. More than likely it does;
- If the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, show your Health Benefit ID Card to the Hospital staff or Physician. If it does not contract with the local Blue Cross and Blue Shield Plan, you will need to pay the bill and file a claim form with Us;
- If the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, the Hospital or Urgent Care Center will verify your eligibility and get your benefit information from a nationwide electronic data system;
- After you are treated, your claim is sent to Us. For Covered Services, you are required to pay any applicable Deductible, Coinsurance or Copayments as stated in your *Health Plan Description Form* (annual Deductible and Coinsurance is waived on Urgent Care, but not Emergency Room); and
- You may receive an Explanation of Benefits form.

Ambulance and Transportation Services

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

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

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

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

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

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

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

If you elect not to receive transport to a facility after an Ambulance has been called, your Copayment will still apply.

Copayment waiver

If you are admitted as an inpatient, any Ambulance Copayment listed on the *Health Plan Description Form* is waived.

Therapy Services

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

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

Physical, Occupational and Speech Therapy

From the Member's birth until the Member's sixth (6th) birthday, benefits are allowed up to the maximum visits listed on the *Health Plan Description Form*, or twenty (20) visits each, whichever is greater, per Benefit Period for Physical, Speech and Occupational Therapies. Benefits are for the care and treatment of Congenital Defects and Birth Abnormalities for covered children without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. From the Member's birth until the Member's third (3rd) birthday, these services shall be provided only where and only to the extent required by applicable law.

For all other Members (e.g. those six (6) and older, or who not qualify for the benefits above), benefits are provided only if the Physical, Speech or Occupational Therapy will result in a practical improvement in the level of functioning within a reasonable period of time and the Physical, Speech or Occupational Therapy must be Medically Necessary. Benefits for Physical, Speech or Occupational Therapy are allowed up to the maximum visits as listed on the *Health Plan Description Form*.

- **Physical Therapy** including treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function and to prevent disability following illness, injury or loss of a body part, or as a result of a Congenital Defect or Birth Abnormality.

- **Speech Therapy** for the correction of a speech impairment resulting from illness, injury, Surgery or as a result of a Congenital Defect or Birth Abnormality as determined by Our medical policy.

    - **Cleft Palate or Cleft Lip**. For a cleft palate or cleft lip condition, Speech Therapy benefits are unlimited, as long as Medical Necessity has been demonstrated. Such Speech Therapy visits reduce the maximum visits but are not limited to the maximum visits. Additional services for cleft palate or cleft lip can be found under the **DENTAL RELATED SERVICES** section of this Benefit Booklet.

- **Occupational Therapy** for the treatment of a person with physical disabilities or as a result of a Congenital Defect or Birth Abnormality by means of constructive activities designed and adapted to promote the restoration of the Member's ability to satisfactorily accomplish the ordinary tasks of daily living. It also includes tasks required by the Member's particular occupational role.

- **Osteopathic Manipulative Therapy Services** to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit. Benefits are allowed up to the maximum visits as listed on the *Health Plan Description Form.*

Other Therapy Services

- **Chiropractic Therapy** services within the scope of chiropractic care that are supportive or necessary to help you achieve the physical state enjoyed before an injury or illness and are generally furnished for the diagnosis and/or treatment of a neuromusculoskeletal condition associated with an injury or illness. Coverage is provided for examinations, office visits with manual manipulation of the spine, x-ray of the spine and conjunctive physiotherapy. Benefits are allowed up to the maximum visits as listed on the *Health Plan Description Form*.

- **Massage Therapy** when it is part of a covered course of Physical Therapy and is provided by a licensed physical therapist or chiropractor, and accumulates toward the maximum number of treatments included under the Chiropractic benefit or Physical Therapy benefit. Coverage is provided for up to a 60 minute session per visit.

- **Acupuncture Services** from an acupuncturist who acts within the scope of his or her license for the treatment of neuromusculoskeltal pain resulting from an injury or illness. Covered Services are allowed up to the maximum visits as listed on the *Health Plan Description Form*.
- **Cardiac Rehabilitation** to restore a Member's functional status after a cardiac event. Benefits are allowed at a facility for exercise and education under the direct supervision of skilled program personnel in an intensive outpatient rehabilitation program. From 6 to 36 visits per cardiac event are allowed based on Our Medical Policy.
- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents. Chemotherapy services can be given at the Providers office. See this "Covered Services" section under Prescription Drugs Administered by a Medical Provider for more information;
- **Dialysis Treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- **Radiation Therapy** for the treatment of disease by x-ray, radium or radioactive isotopes.
- **Inhalation Therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

Physical Medicine and Rehabilitation Services

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

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

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

Home Care/Home IV Therapy Services

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

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

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.);
- Medical/social services;
- Diagnostic Services;
- Nutritional guidance;
- Certified Nurse Aide services under the supervision of an R.N. or a therapist qualified with professional nursing services;
- Therapy Services (not subject to the therapy limits listed on the *Health Plan Description Form* when provided by a Home Care Agency);
- Medical and Surgical Supplies;
- Durable Medical Equipment;
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).

Home IV Therapy

Home IV Therapy is covered and includes a combination of nursing, Durable Medical Equipment and IV pharmaceutical services that are delivered and/or administered intravenously in the home. Home IV Therapy includes

services and supplies such as for Total Parenteral Nutrition (TPN), Antibiotic therapy, pain management and Chemotherapy. TPN received in the home is a covered benefit for the first 21 days following a Hospital discharge when it is determined to be Medically Necessary. Additional days may be allowed up to a maximum of 42 days per Benefit Period when Preauthorized by Us.

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

See this "Covered Services" section under Prescription Drugs Administered by a Medical Provider for more information.

Nutritional Counseling

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

Nutritional counseling is a process of reviewing food habits and choices with a nutrition expert who offers diet modifications and suggestions appropriate for you. The goal of nutrition counseling is to optimize food choices, nutritional quality and dietary supplements in your diet. Benefits are provided for a Registered Dietitian who is a health care professional educated in nutrition and foods and who is able to translate scientific information into appropriate food choices. Registered Dietitians must limit their practice to those methods and/or modalities which are in conformity to all applicable state and federal laws. Coverage is provided for up to a 60 minute session per visit. Benefits are allowed up to the maximum visits as listed on the *Health Plan Description Form* included at the front of this Benefit Booklet.

Coverage includes nutritional techniques of evaluation which provides measurements and assessments, nutritional counseling, nutritional therapy and advice on nutritional supplements. Coverage is not provided for foods, hypnotherapy, personal training, supplements or vitamins.

Medical Foods

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

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

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

Hospice Care Services

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

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

Hospice Services include:

- Hospice day care;
- Home Care services;
- Skilled nursing services (by an R.N. or L.P.N.);
- Social/counseling services;
- Physician services;

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

Human Organ and Tissue Transplant Services

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

The human organ and bone marrow/stem cell transplant and transfusion services, benefits or requirements do not apply to the following Covered Services:

- Kidney;
- Cornea;
- Any Covered Services related to a Covered Transplant Procedure received prior to or after the transplant benefit period. Note: the harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above Covered Services are paid as Physician Office Services, Inpatient Services and Outpatient Services, depending on where the service is performed. Benefits are excluded for transportation, lodging and meals for those services listed above.

The following services for Human Organ and Tissue Transplants are covered when provided as part of Physician Office Services, Inpatient Services, and Outpatient Services.

We shall provide benefits for Medically Necessary Human Organ and Tissue Transplant services only when We have Preauthorized the services. Benefits include coverage for necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy. Covered Transplant Procedures include treatment of breast cancer by high-dose Chemotherapy with autologous bone marrow transplantation.

We must designate and approve the Hospital that is performing the specific Covered Services provided under this benefit. Please note, not every designated Hospital performs each of the specified Covered Services. Even if a Hospital is an In-Network Provider for other Covered Services, it may not be an approved Hospital for Human Organ and Tissue Transplants.

You can contact the transplant case manager for information on the Human Organ and Tissue Transplant Covered Services available under this Benefit Booklet.

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

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

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

We may amend the above covered transplant services list to include additional organ or tissue transplants or combinations of transplants based on Our medical policy.

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

Only those Human Organ and Tissue Transplants and directly related procedures specified in this section are Covered Services under this benefit. Benefits will only be provided for Covered Services and supplies furnished to the transplant recipient starting one day prior to a Covered Transplant Procedure and continuing at the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the In-Network Provider agreement. At the end of this case rate/global time period benefits are provided under the **PHYSICIAN OFFICE SERVICES, INPATIENT SERVICES** and **OUTPATIENT SERVICES** sections, depending on where the service is performed and are not subject to the terms of this **HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES** section of this Benefit Booklet.

Other services

- Provider requested HLA testing, donor searches and/or a harvest or 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 Diagnostic Services. See the **DIAGNOSTIC SERVICES** section for more information. If coverage is provided for HLA testing, donor searches and/or a harvest and storage it is not an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made to the transplant procedure.
- Immunosuppressant drugs prescribed for outpatient use in connection with a covered Human Organ and Tissue Transplant that are dispensed only by written prescription and that are approved for general use by the Food and Drug Administration, but only if your coverage has a Prescription Drug benefit.
- We will provide assistance with reasonable and necessary travel expenses as determined by Us, when you receive prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the covered facility and lodging for the covered Member and one companion. If the Member receiving the 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 Us when claims are filed. You may contact Us for detailed information. No benefits will be paid until after the transplant services are received. For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code. Benefits for transportation and lodging are limited to a maximum benefit as listed on the *Health Plan Description Form*.

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

- When both the recipient and the donor are Our Members, each is entitled to the Covered Services specified in this section of this Benefit Booklet.
- When only the recipient is a Member, both the donor and the recipient are entitled to the Covered Services specified in this section of this Benefit Booklet.

- The donor benefits are limited to those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, grants, foundations, government programs, etc.
- If the donor is Our Member, and the recipient is not covered by Us, benefits will not be provided for the donor or recipient expenses.

Coverage includes Covered Services related to the live donor and/or donated organ or tissue, such as Hospital, surgical, medical, storage and transportation costs (including complications from the donor procedure for up to 6 weeks from the date of procurement).

Benefits are provided for unrelated donor searches for bone marrow/stem cell transplants for the Members for a Covered Transplant Procedure. Benefits for unrelated bone marrow/stem cell donor searches are limited to the maximum as listed on the *Health Plan Description Form*.

Medical Supplies, Durable Medical Equipment, and Appliances

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

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

Medical and Surgical Supplies

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

Custom-designed Orthotics when prescribed by a Physician and required for all normal, daily activities are also included as a Covered Service.

Durable Medical Equipment

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

Prosthetic Devices

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

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

For prosthetic arms and legs the benefits shall be provided equal to those benefits provided by federal laws for health insurance for the aged and disabled.

Benefits for prosthetic devices include:

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

Orthopedic Appliances

Benefits are provided for the purchase, fitting, needed adjustment, repairs, and replacements of Orthopedic Appliances and supplies that are rigid or semi-rigid supportive devices and that limit or stop motion of a weak or diseased body part.

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

Hearing Aid Services

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

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

Dental Related Services

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

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

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

Dental Anesthesia

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

Cleft Palate and Cleft Lip Conditions

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

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

Mental Health Care, Alcohol Dependency and Substance Dependency Services

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

Inpatient Services, Outpatient Services and Physician Office Services for the treatment of Mental Health Conditions, Alcohol Dependency or Substance Dependency are covered for the diagnosis, crisis intervention and short-term treatment of Mental Health Conditions and for the rehabilitation of Alcohol Dependency or Substance Dependency.

Mental health care is coverage for conditions identified as mental disorders in the most 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 require specific psychotherapeutic treatment, regardless of the underlying condition. Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) care is covered under the mental health care benefit if the services are provided by a licensed mental health provider.

Alcohol/Substance Dependency benefits are for acute medical detoxification and for alcohol/Substance Dependency rehabilitation received from an Alcoholism Treatment Center. Alcohol/Substance Dependency is a condition that develops when an individual uses alcohol and/or other drug(s) in such a manner that the Member's health is impaired and/or the ability to control actions is lost. The main purpose of medical detoxification is to rid the body of toxins, monitor heart rate, blood pressure and other vital signs, manage withdrawal symptoms and administer medications as needed. Benefits are provided for rehabilitation for Alcohol or Substance Dependency conditions on inpatient or outpatient basis from an Alcoholism Treatment Center for treatment that will assist the Member to live without abusing alcohol or drugs. If the Member is admitted for an unscheduled Emergency admission, notification requirements can be found below under the "Preauthorizations" heading.

Non-emergent services will be paid only if you or your Provider obtain prior approval from Our Mental Health, Alcohol Dependency or Substance Dependency Subcontractor and receive services from the Provider designated by that Preauthorization.

Benefits are provided for medication management for Mental Health Conditions provided by your medical Provider, psychiatrist or prescriptive nurse. If the medication management is provided by your medical Provider, benefits are paid under your medical benefit. If medication management is provided by a psychiatrist or a prescriptive nurse, benefits are paid under the mental health benefit. For coverage of Prescription Drugs, see the **PRESCRIPTION DRUG** section of this Benefit Booklet.

Preauthorizations. The Member's Provider should contact Our behavioral health administrator to determine medical necessity, appropriate treatment level and appropriate setting. Non-emergent **I**npatient Services are subject to Preauthorization notification guidelines. See the MANAGED CARE FEATURES heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on Preauthorization guidelines. Our behavioral health administrator must be notified for all Emergency admissions by the next business day unless the Member is unable to do so.

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

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

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

Partial Hospitalization Services. The same services covered for Outpatient Services for Mental Health, Alcohol and Substance Dependency are also covered for partial hospitalization. Partial hospitalization treatment is covered only when the Member receives Medically Necessary care through a day treatment program as determined by the facility.

Prescription Drugs Administered by a Medical Provider

We cover Prescription Drugs when they are administered to you as part of a Physician's visit, home care visit, or at an outpatient facility. This includes drugs for infusion therapy, chemotherapy, specialty drugs, and blood products. This section describes your benefits when your Provider orders the medication and administers it to you. Benefits are also available for Prescription Drugs that you receive from a Retail Pharmacy, Home Delivery Pharmacy, or through the Specialty Pharmacy. See the "Covered Services" section for more information.

Note: When benefits are provided for Prescription Drugs under this section, they will not also be provided under the Retail Pharmacy/Home Delivery Pharmacy Prescriptions Drug, or Specialty Pharmacy Drugs sections. In addition, if

benefits are provided for Prescription Drugs under the Retail Pharmacy/Home Delivery Pharmacy Prescriptions Drug, or Specialty Pharmacy Drugs sections, they will not also be provided under this section.

Important Requirements for Prescription Drug Coverage

Your plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your Physician may be asked to provide additional information before We can determine if Medically Necessary. We may also establish quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Pharmacy and Therapeutics (P&T) Process.

Preauthorization

Preauthorization may be required for certain Prescription Drugs (or the quantity of a particular drug) to ensure appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. We will contact your Provider to obtain additional information required to determine whether Preauthorization should be granted. We will communicate the results of the decision to both you and your Provider.

For a list of the current drugs requiring Preauthorization, please call the phone number on your Health Benefit ID Card. The list is subject to periodic review and amendment. Inclusion of a Prescription Drug or related item on the list is not a guarantee of coverage under this Benefit Booklet. Your Provider may check with Us to verify Prescription Drug coverage, to determine whether any quantity and/or age limits apply, and to determine applicable brand or generic drugs covered under this Benefit Booklet.

Step Therapy

Step therapy refers to the process in which you may be required to use one type of medication before benefits are available for another. We monitor certain Prescription Drugs to control utilization and to ensure that appropriate prescribing guidelines are followed. These guidelines help you access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed, the Preauthorization process is applied.

Therapeutic Substitution

Therapeutic substitution is a voluntary program designed to inform you and your Physician about possible alternatives to certain prescribed drugs. We may contact you and your prescribing Physician to make you aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is requested. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you. For questions or issues involving therapeutic drug substitutes, please call the phone number on your Health Benefit ID card. The therapeutic drug substitutes list is subject to periodic review and amendment.

Retail Pharmacy/Mail Order Prescription Drugs

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

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

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

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

The Outpatient Pharmacy benefits available under this Benefit Booklet are managed by the Pharmacy Benefits Manager (PBM). The PBM is the entity with which We have contracted to administer its prescription drug benefits. The PBM offers a nationwide network of Retail Pharmacies, a Mail-Service Pharmacy, a Specialty Pharmacy and clinical services. You may review the current Formulary Prescription Drug list on Our website at www.anthem.com, under prescription benefits. You may also request a copy of the Formulary/drug list by calling Our customer service

department. The Formulary/drug list is subject to periodic review and amendment. Inclusion of a drug or related item on the Formulary/Prescription Drug list is not a guarantee of coverage.

For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before We will determine Medical Necessity. We may, at Our sole discretion, establish quantity limits for specific Prescription Drugs. The PBM, in consultation with Us also promotes and enforces the appropriate use of medications by reviewing for improper dosage, potential drug to drug interactions or drug-disease state interactions. Your Copayment amount depends on whether the drug you receive is a first, second, third or fourth tier drug. See the *Health Plan Description Form* to determine the associated Copayment for each tier. Note: a prescription drug annual Deductible per Member (separate from the medical annual Deductible) will apply to Tier 2 and Tier 3 drugs.

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

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

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

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

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

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

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

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

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

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

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

Outpatient Pharmacy benefits received from an In-Network Pharmacy or Mail Service 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 contraceptives are covered under Preventive Care Services;
- Certain supplies, equipment and appliances (such as those for diabetes). You may contact Us to determine supplies covered through a Pharmacy; and

- Smoking cessation Prescription Drugs.

Each prescription is subject to a Copayment, and a prescription drug annual Deductible per Member (separate from the medical annual Deductible) will apply to Tier 2 and Tier 3 drugs. 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 make no payment for any covered drug or supply unless the Prescription Drug Maximum Allowed Amount exceeds any applicable Copayment for which you are responsible. See *the Health Plan Description Form* to determine the associated Copayment.

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

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

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

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

Prescription Drugs will always be dispensed as ordered by your Physician and by applicable State Pharmacy Regulations. You may request, or your Provider may order, a Brand Name Drug. If you purchase a Tier 2, Tier 3 or Tier 4 prescription drug when there is a FDA rated equivalent prescription Tier 1 drug available, you are responsible for the Tier 2, Tier 3 or Tier 4 Copayment for the prescription drug and you will pay the difference between the cost of the Tier 1 prescription drug and the cost of the Tier 2, Tier 3 or Tier 4 prescription drug. For example: a Tier 2 prescription costs $50; a Tier 1 substitution is available, the Tier 1 prescription costs $20, you pay the $30 difference plus the Tier 2 Copayment not to exceed the negotiated rate of the drug. The $30 difference is not applied towards any other Cost Sharing requirement. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using Generics generally saves money, yet provides the same quality. We reserve the right, at Our discretion, to remove certain higher cost Generic Drugs from this Plan.

Mail Service Program

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

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

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

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

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

Specialty Pharmacy

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

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

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

The Outpatient Specialty Pharmacy benefits available under this Benefit Booklet are provided by the PBM. The PBM is the entity with which HMO Colorado has contracted to administer its prescription drug benefits. The PBM Specialty Pharmacy is a full service Specialty Pharmacy which ships medications to you by overnight mail or common carrier for up to a 90-day supply (you cannot pick up your medication from the PBM Specialty Pharmacy). Certain Specialty Pharmacy Drugs may not be eligible to be purchased for a 90-day supply due to the nature of the medication. The PBM Specialty Pharmacy is not a Retail Pharmacy or a Mail Service Pharmacy. We have established a Pharmacy and Therapeutics (P&T) Process, in which health care professionals, including nurses, pharmacists and doctors determine the clinical appropriateness of drugs and promote access to quality medications. This process also reviews drugs to determine the most cost effective use of benefits and advise on programs to help improve care. Our programs may include, but are not limited to, drug utilization programs, Preauthorization criteria, therapeutic conversion programs, cross-branded initiatives and drug profiling initiatives.

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

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

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

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

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

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

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

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

Note: a prescription drug annual Deductible per Member (separate from the medical annual Deductible) will apply to Tier 2 and Tier 3 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. If you purchase a Tier 2, Tier 3 or Tier 4 prescription drug when there is a FDA rated equivalent prescription Tier 1 drug available, you are responsible for the Tier 2, Tier 3 or Tier 4 Copayment for the prescription drug and you will pay the difference between the cost of the Tier 1 prescription drug and the cost of the Tier 2, Tier 3 or Tier 4 prescription drug. For example: a Tier 2 prescription costs $50; a Tier 1 substitution is available, the Tier 1 prescription costs $20, you pay the $30 difference plus the Tier 2 Copayment not to exceed the negotiated rate of the drug. The $30 difference is not applied towards any other Cost Sharing requirement. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using Generics generally saves money, yet provides the same quality. We reserve the right, at Our discretion, to remove certain higher cost Generic Drugs from this Plan.

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 make no payment for any covered drug or supply unless Our Prescription Drug Maximum Allowed Amount exceeds any applicable Copayment for which you are responsible. See the *Health Plan Description Form* to determine the associated Copayment.

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

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

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

You may also contact the Specialty Pharmacy PBM at:

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

Exception Process for Specialty Pharmacy Drugs

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

Clinical Trials

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

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 **GLOSSARY** section of this Benefit Booklet):

- The treating Provider recommends participation in the clinical trial after determining that participation has the potential to provide therapeutic health benefit to the Member;
- The clinical trial or study is approved under the September 19, 2000, Medicare National Coverage Decision regarding clinical trials, as amended;
- The treating Provider is a certified, registered, or licensed health care Provider practicing within the scope of his/her expertise and the facility and personnel providing the treatment have the experience and training to provide treatment in a competent manner;
- Prior to participation in a clinical trial or study, the Member signed a consent indicating that the Member has been informed of the procedure, risks and that any coverage is in accordance with this Benefit Booklet (including the application of out of network cost shares); and
- The Member suffers from a condition that is disabling, progressive, or life-threatening.

GENERAL EXCLUSIONS

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

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

1. That We determine are not Medically Necessary. Emergency Care is not subject to this exclusion as long as such care meets the definition of Emergency Care, see the **Emergency Care and Urgent Care** section of this Benefit Booklet;

2. For care received from an Out-of-Network Provider, except for Emergency Care, Urgent Care or as Preauthorized by Us as a Covered Service;

3. Received from an individual or entity that is not a Provider, as defined in this Benefit Booklet;

4. That are Experimental/Investigational or related to such, whether incurred before, in connection with, or subsequent to the Experimental/Investigational service or supply, as determined by Us;

5. To the extent they are available as benefits through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits under this Benefit Booklet will be coordinated with such governmental units to the extent required under existing state and/or federal laws;

6. For which benefits are payable under Medicare Part A and/or Medicare Part B, unless otherwise specified in this Benefit Booklet or as otherwise prohibited by federal law, as addressed in the section titled **Medicare** in **ADMINISTRATIVE INFORMATION**;

7. In excess of the Maximum Allowable Amount for Medical Supplies, Durable Medical Equipment and appliances unless otherwise specified in this Benefit Booklet;

8. Incurred before your Effective Date;

9. Incurred after the termination date of this coverage unless otherwise specified in this Benefit Booklet;

10. For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Cosmetic Services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for Surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies or previous therapeutic process or pursuant to breast reconstruction following a mastectomy. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Benefit Booklet. Other reconstructive services are not covered except as specifically required by applicable law;

11. For services performed to maintain or preserve the present level of function or prevent regression of function for an illness, injury or condition that is resolved or stable;

12. For Dental Services. Excluded dental services include, but are not limited to, preventive care and fluoride treatments; dental x-rays, supplies, appliances and all associated expenses; and diagnosis and treatment related to the teeth, jawbones or gums such as extraction (including 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 Benefit Booklet;

13. Weight loss programs, whether or not they are pursued under medical or Physician's supervision, unless otherwise specified in this Benefit Booklet;

14. Treatment of obesity, except for surgical treatment of morbid obesity (bariatric Surgery) up to the maximum benefit as listed on the *Health Plan Description Form*;

15. For research studies or screening examinations, unless otherwise specified in this Benefit Booklet;
16. For stand-by charges of a Physician;
17. Routine exams required as a condition of employment, for licensing, sport programs, insurance, church, or camp.
18. For Private Duty Nursing Services, except when provided through the Home Care Services or Hospice Care Services sections of this Benefit Booklet;
19. Related to male or female sexual or erectile dysfunction or inadequacies, regardless of origin or cause. This exclusion includes Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency;
20. Nutritional and/or dietary supplements, unless otherwise specified in this Benefit Booklet or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist;
21. For complications arising from non-Covered Services and supplies;
22. Related to your leaving a Hospital or other facility against the medical advice of the Physician;
23. For services or supplies for the treatment of Intractable Pain and/or Chronic Pain;
24. Services that exceed the Benefit Period Maximum payments as listed in the Benefit Booklet or *Health Plan Description Form*, even if you have satisfied the Out-of-Pocket Annual Maximum;
25. Breast reduction Surgery (reduction mammoplasty) or services related to breast reduction Surgery, unless the breast reduction Surgery is performed as a result of breast cancer;
26. For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party, except as specified under the **ADMINISTRATIVE INFORMATION** section;
27. For any illness or injury that occurs as a result of any act of war, declared or undeclared, while serving in the military, or services and supplies furnished by a military facility for disabilities connected to military service;
28. For a condition resulting from a riot, civil disobedience, nuclear explosion or nuclear accident;
29. For court-ordered testing or care unless Medically Necessary and Preauthorized by Us;
30. For which you have no legal obligation to pay in the absence of this or like coverage;
31. Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group;
32. Prescribed, ordered or referred by, or received from, a member of your immediate family (parent, child, Spouse, sister, brother or self);
33. For completion of claim forms or charges for medical records or reports, unless otherwise required by law;
34. For missed or canceled appointments;
35. For mileage costs or other travel expenses, except as Preauthorized by Us;
36. For Custodial Care, or domiciliary or convalescent care, whether or not recommended or performed by a professional;
37. For foot care to improve comfort or appearance including, but not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails;
38. For sex transformation Surgery and related services, or the reversal thereof;
39. For marital counseling or personal growth;

40. For eyeglasses, contact lenses or their fitting, vision therapy or routine vision exams, unless otherwise specified in this Benefit Booklet. Routine vision exam benefits are provided under separate vision coverage. Information on your vision benefits included in this Plan can be found in Part 2 of this Benefit Booklet;

41. For hearing aid services, unless otherwise specified in this Benefit Booklet;

42. For services or supplies primarily for educational, vocational, or training purposes, unless otherwise specified in this Benefit Booklet;

43. Services to reverse voluntarily induced sterility;

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

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

46. For or related to services (including but not limited to Speech Therapy) for dysfunctions that are self-correcting such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting, learning disabilities, behavioral problems, hyperkinetic syndromes or mental retardation (except for Prescription Drugs for treatment of these conditions if Prescription Drugs are a covered benefit);

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

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

49. 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;

50. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas;

51. For self-help training and other forms of non-medical self care, unless otherwise specified in this Benefit Booklet;

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

53. For peripheral bone density scans;

54. For storage or other administrative costs, except when provided as part of the Inpatient Services and Human Organ and Tissue Transplant Services;

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

56. For the cost of donor sperm or donor eggs, storage costs for sperm or frozen embryos, or diagnostic tests to determine the effectiveness of a procedure designed to promote fertility or pregnancy;

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

58. For rolfing therapy, Myotherapy or prolotherapy;

59. For Ambulance transportation if you could have been transported by private automobile or by commercial or public transportation without endangering your health or safety;

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

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

62. For items usually stocked in the home for general use like Band-Aids, thermometers and petroleum jelly.

63. Language training for educational, psychological or speech delays;

64. Diversional, recreational or vocational therapies such as hobbies, arts and crafts;

65. Sclerotherapy for the treatment of varicose veins in the lower extremities, including ultrasonic guidance for needle and/or catheter placement and subsequent sequential Ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy. Treatment of telangiectatic dermal veins (spider veins) by any method;

66. For any services or supplies provided to a person not covered under the Benefit Booklet in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple);

67. Cardiac Rehabilitation home programs, on-going conditioning and maintenance, unless otherwise specified in this Benefit Booklet;

68. For elective termination of pregnancy;

69. 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; and

70. For Acupuncture Services primarily for the purpose of weight control, related to menstrual cramps and addiction including smoking cessation.

Human Organ and Tissue Transplant Services

We do not provide benefits for services, supplies, conditions, situations or charges for the following Human Organ and Tissue Transplant Services:

1. Human Organ and Tissue Transplant services that are performed at any Hospital that is not designated or approved by Us for the organ or tissue being transplanted;

2. If you are not a suitable candidate as determined by the Hospital designated and approved by Us to provide Human Organ and Tissue Transplant services;

3. For donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or for their respective family members or friends unless otherwise specified in this Benefit Booklet;

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

5. For transplants of organs other than those listed in the **HUMAN ORGAN AND TISSUE TRANSPLANT** section of this Benefit 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;

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

    - Alcohol, tobacco, other non food items;
    - Meals;
    - Child care;
    - Mileage within the medical transplant facility city;
    - Rental care, buses, taxis, or shuttle services, except as specifically approved by Us;
    - 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;
- Telephone calls;
- Laundry;
- Postage;
- Entertainment;
- Interim visits to a medical care facility while waiting for the actual transplant procedure;
- Travel expenses for donor companion/caregiver; and
- Return visits for the donor for a treatment of a condition found during the evaluation.

Retail Pharmacy Prescription Drugs

We do not provide benefits for services, supplies, conditions, situations or charges for the following Retail Pharmacy Prescription Drugs:

1. Prescription Drugs and supplies received from an Out-of-Network Pharmacy;
2. Prescription Drugs and supplies received as an inpatient in a Hospital or other covered inpatient facility, except where covered as part of the inpatient stay;
3. Non-legend Prescription Drugs;
4. Drugs prescribed for weight control or appetite suppression;
5. Medication or preparations used for cosmetic purposes to promote hair growth, prevent hair growth, or medicated cosmetics. These included but are not limited to Rogaine®, Viniqa®, and Tretinoin (sold under such brand names as Retin-A®);
6. 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 Physician'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 **PRESCRIPTION DRUG** 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. Drugs for treatment of sexual or erectile dysfunction or inadequacies, regardless of origin or cause and even if the dysfunction is a side effect of, or related to another covered disease or illness; or

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

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

22. Replacement of lost or stolen Prescription Drugs.

Specialty Pharmacy Drugs

We do not provide benefits for services, supplies, conditions, situations or charges for the following Specialty Pharmacy Drugs;

1. When benefits are provided under the Specialty Pharmacy benefits they will not be provided under the "Covered Services" section of this Benefit Booklet, including without limitation Specialty Pharmacy Drugs administered by a medical Provider; or

2. When benefits are provided under the Specialty Pharmacy benefits they will not be provided under the **Retail Pharmacy Prescription Drug** section of this Benefit 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

We do not provide benefits for services, supplies, conditions, situations or charges for the following 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 rehabilitation unless otherwise specified in this Benefit Booklet;

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

5. Rental or purchase of Durable Medical Equipment unless otherwise specified in this Benefit Booklet;

6. Treatment primarily for purpose of weight control;

7. Laboratory 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; and

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

Clinical Trials

We do not provide benefits for services, supplies, conditions, situations or charges for the following Clinical Trials;

1. Any portion 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. Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that a Member or person accompanying a Member may incur;
4. An item or service that is provided solely to satisfy a need 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 Benefit Booklet; or
7. Any service or procedure related to the diagnosis, treatment or prevention of complications related to a clinical trial.

ADMINISTRATIVE INFORMATION

Insurance Premiums

How Costs are Established and Changed – The costs and fees described in this section are the monthly charges you and/or the Employer must pay Us to establish, administer and maintain coverage. We determine and establish the required fees and charges.

As this Plan is self-funded, the Employer is responsible for paying claims covered by the Plan and responsible for paying the administrative fees to Us according to the terms of the Administrative Services Agreement. Employers may require their employees to contribute to these costs through payroll deduction.

How to File Claims

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

If an Out-of-Network Provider does not bill Us directly, you must file the claim. To obtain claim forms, contact Our customer service department or obtain from Our web site at www.anthem.com. If We do not furnish a claim form to you within 15 days of your request, you may submit written proof of the claim and will be considered to have complied with the requirements of this Benefit 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 currency. To determine the United States currency amount, use the exchange rate as it was on the date you received care. If information is missing on the claim form or is not readable, the form will be returned to you. The information contained on the itemized bills will be used to determine benefits, so it must support information reported on the submitted claim form. The claim form contains detailed instructions on how to complete the form and what information is necessary.

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

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

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

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

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

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

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for Covered Services that does not reflect the entire savings realized, or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard® method noted above or require a surcharge, We will then calculate your liability for any Covered Services in accordance with the applicable state statute in effect at the time you received care.

You will be entitled to benefits for health care services you received either inside or outside the geographic area We serve if this Benefit Booklet covers those health care services. Due to variations in Host Blue medical practice protocols, you may also be entitled to benefits for some health care services obtained outside the geographic area We serve, even though you

might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area We serve. But in no event will you be entitled to benefits for health care services wherever you received them that are specifically excluded or limited from coverage by this Benefit Booklet.

Care Outside the United States BlueCard Worldwide - Prior to travel outside the United States, check with your employer or call the Customer Service number on the ID card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and Anthem recommends:

- Before leaving home, call the customer service number on the ID card for coverage details.
- Always carry the current ID card.
- In an emergency, go directly to the nearest Hospital.
- 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 Physician 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 be hospitalized or needs inpatient care. After calling the Service Center, you must also call Us for Preauthorization, at the phone number on the 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 (noncovered services, Deductible, Copayments and Coinsurance) normally paid. The Hospital should submit the claim on your behalf.
- Physicians and/or non-participating hospitals - You will need to pay upfront for outpatient services, care received from a Physician, 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.
- You must file the claim for outpatient and Physician 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.

Where and When to Send Claims - A claim must be filed **within 180 days** after the date of service. Any claims filed after this limit may be refused. Failure to file a claim within such time will not invalidate or reduce any claim if it is shown that it was not reasonably possible to give such notice and that notice was given as soon as reasonably possible.

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

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

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

Upon your death, any claims payable to you under the terms of this Benefit Booklet will be payable in accordance with the beneficiary designation. If no such designation is in effect, any claims payable to you will be paid to your estate. If the Provider is an In-Network Provider, claims payments will be made to the Provider.

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

General Provisions

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

Changes to the Benefit Booklet - If We amend this Benefit Booklet to modify benefits, notice of the amendment will be given to the Employer no less than 90 days before to the Effective Date of such change and the amendment(s) will be effective for each group on the renewal or Anniversary Date of the policy.

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

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

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

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

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

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

- Be wary of offers to waive Copayments, 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 or available on the www.anthem.com website. If there are any discrepancies, call Our customer service department.
- Be very cautious about giving your health insurance coverage information over the phone.

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

We reserve the right to recoup any benefit payments paid on your behalf, and/or rescinding your membership under this Benefit 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. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days' advance written notice of such action.

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

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

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

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

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

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

Medicare – Any benefits covered under both this Benefit 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 whenever there is a conflict among state law, Benefit Booklet provisions, and federal law. Except when federal law require Us to be the primary payor, the benefits under this Benefit 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 reimbursed by or on your behalf to Us, to the extent We have made payment for such services.

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

Non-Contestable - This Benefit Booklet shall not be contested, except for nonpayment of Premiums by the Employer, after it has been in force for two years from its date of issue. No statement made to effect coverage under the Benefit 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 Benefit 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 furnished to the Member making the statement or to the beneficiary of any such Member.

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

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

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

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

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

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

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

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

Anthem has oversight responsibility for compliance with Provider and vendor and subcontractor contracts. Anthem 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 feasible.

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

Refusal to Follow Recommended Treatment - If you refuse treatment that has been recommended by one of Our Providers, the Provider may decide that your refusal compromises the Provider-patient relationship and obstructs the provision of proper medical care. Providers will try to render all necessary and appropriate professional services according to your wishes, when they are consistent with the Provider's judgment. If you refuse to follow the recommended treatment or procedure, you are entitled to see another Provider of the same specialty for a Second Opinion. You can also pursue the Appeal process.

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

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

Workers' Compensation

To recover benefits under workers' compensation insurance for a work-related illness or injury, you must pursue your rights under the Workers' Compensation Act or any of the employer liability laws that may apply. This includes filing an

Appeal with the Division of Workers' Compensation. We may pay conditional claims during the Appeal process if you sign a reimbursement agreement to reimburse Us for 100 percent of benefits paid that duplicate benefits paid from another source.

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

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

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

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

Automobile Insurance Provisions

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

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

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

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

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

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

We will also pay benefits under the terms of the Benefit Booklet for injuries you sustain if as a non-owner-operator, passenger or pedestrian involved in a motor vehicle accident if those injuries are not covered by a complying policy. In

that event, We may exercise the rights found in the **ADMINISTRATIVE INFORMATION** section, under the heading *Third Party Liability: Subrogation and Right of Reimbursement*.

Third Party Liability: Subrogation and Right of Reimbursement

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

Subrogation

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

- We have the first priority lien for the full amount of benefits We have paid from any Recovery, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, your own insurer (for example, uninsured, underinsured, medical payments or no-fault coverage, or a workers' compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness. Our first priority lien exists regardless of whether you are fully compensated, and regardless of whether the payments you receive makes you whole for losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Benefit Booklet.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, beneficiary's claims (if applicable), your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs incurred without Our prior written consent. You and We further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney hired regardless of whether funds recovered are used to repay benefits paid by Us.

Right of Reimbursement

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

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

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

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

The Member's Duties

- You, your legal representative, or beneficiary must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You, your legal representative, or beneficiary must cooperate with Us in the investigation, settlement and protection of its rights.
- You, your legal representative, or beneficiary must not do anything to prejudice Our rights.
- You, your legal representative, or beneficiary must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness.
- You, your legal representative, or beneficiary must promptly notify Us if you retain an attorney or if a lawsuit is filed.
- If you, your legal representative, or beneficiary resides in a state where automobile personal injury protection or medical payment coverage is mandatory, that coverage is primary and the Benefit Booklet takes secondary status. The Benefit 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.

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

Duplicate Coverage and Coordination of Benefits

We coordinate benefits when you have duplicate coverage.

Duplicate Coverage - Duplicate coverage exists when you are covered by this plan 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 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 plans is through active employment, the coverage through active employment is primary.

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

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

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

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

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

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

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

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

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

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

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

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

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

How We Coordinate Benefits - When We are the primary coverage, We pay benefits under the terms of this Benefit 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 Benefit 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 This Plan – We will be the primary payer for persons age 65 and older with Medicare coverage. Medicare will be the primary payer for persons age 65 and older with Medicare coverage if the Subscriber is not actively working 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.

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

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

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

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

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

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

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

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

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

COMPLAINTS, APPEALS AND GRIEVANCES

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

Complaints

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

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

Appeals

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

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

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

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

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

Notice of Adverse Benefit Determination

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

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which Our determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on medical necessity or Experimental/Investigational treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

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

Appeals

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

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

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

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

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

HMO Colorado
ATTN: Appeals
700 Broadway, Mail Stop CO0104-0430
Denver, CO 80273

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

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

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

How Your Appeal will be Decided

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

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

Voluntary Second Level Appeals

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

External Review

If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

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

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

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

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

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

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

Anthem Blue Cross and Blue Shield
ATTN: Appeals
P.O. Box 54159, Los Angeles, CA 90054

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this Plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties unless the Board of Trustees for the City and County of Broomfield Employees' Medical Care Expense Plan decides otherwise.

Appeal to Board of Trustees— If a Member wants to have the denied claim reviewed further after the first Appeal without pursuing the Voluntary Second Level Appeal or the External Appeal or wishes to obtain further documents related to the Plan, the Member must send a written request for review of the claim denial or documents to the Board of Trustees for the City and County of Broomfield Employees' Medical Care Expense Plan, Attention:

Human Resources Department
City and County of Broomfield
One DesCombes Drive
Broomfield, CO 80020

The request for a review of a claim denial must be postmarked no later than 60 days after the date the claim Appeal denial by Us is postmarked. Any Member filing a timely request for a review may:

- Submit additional material for consideration, including a written explanation of the issues and comments on the issues, and
- Review, upon request, all Plan documents under Our control which relate to the Member's claim.

Final Decision — The Board of Trustees shall, within 60 days of the date the request for a review of the claim denial is postmarked, provide the claimant with a written opinion regarding the Member's denied claim. Any dispute as to eligibility, amount or duration of benefits under the Plan shall be resolved by the Board of Trustees under and pursuant to the terms of this Benefit Booklet and the Stop-Loss Contract. The decision of the Board of Trustees shall be final, binding, and conclusive.

Requirement to file an Appeal before filing a lawsuit

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

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

NOTE: As a nonfederal governmental benefit program, this Plan is not subject to the federal Employee Retirement Income Security Act, 29 USC 101, et seq. (ERISA). The rules contained in this Benefit Booklet apply to your claims.

Grievances

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

HMO Colorado
Quality Management Department
700 Broadway MC CO0105-0532
Denver, CO 80273-0001

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

Regulatory Inquiries

As this benefit Plan is self-funded by the Employer, it is typically not subject to regulation by the Colorado Division of Insurance. Nonetheless, 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.

Legal Action

Before you take legal action on a claim decision, you must first follow the process outlined under the **Appeals** heading in this section and you must meet all the requirements of this Benefit Booklet. To the extent required by applicable law, if you have exhausted all mandatory levels of review in the Appeals heading in this section, 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 action in law or in equity shall be brought to recover on this Benefit Booklet before the expiration of 60 calendar days after a claim has been filed in accordance with the requirements of this Benefit Booklet. No such action shall be brought at all unless brought within three years after claim has been filed as required by the Benefit Booklet.

GLOSSARY

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

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

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

Acute Rehabilitation Therapy - Inpatient Rehabilitation Therapy that is required for a short period of time. Acute Rehabilitation Therapy services are unrelated to acute Hospital medical or surgical care.

Administrative Services Agreement — the agreement between Anthem Blue Cross and Blue Shield and the Employer, regardless of how such an agreement may be titled, stating all the terms and provisions applicable to the administration of this Plan.

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

Alcoholism Treatment Center - an accredited or licensed Hospital, or any other public or private facility or portion thereof providing services especially for the treatment of Alcohol Dependency which is licensed as such for those services.

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

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

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

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

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

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

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

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

- General Anesthesia, also known as total body Anesthesia, causes the patient to become unconscious or “put to sleep” for a period of time

- Local Anesthesia causes loss of feeling or numbness in a specific area and is usually injected with a local anesthetic drug such as Lidocaine

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

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

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

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

Benefit Period - Your Benefit Period is based on a calendar year and begins on the Subscriber's Effective Date, and expires on the following December 31; a new Member's Benefit Period commences on each subsequent January 1.

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

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

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

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

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

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

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

Certificate of Creditable Coverage – the document We will send you upon your termination of coverage with Us which will identify the length of your Creditable Coverage with Us.

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

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

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

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

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

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

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

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

Complaint - an expression of dissatisfaction with Our services or the practices of an In-Network Provider, whether medical or non-medical in nature.

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

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

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

Cosmetic Services - Cosmetic Services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons.

Cost Sharing - the general term used for Out-of-Pocket expenses you pay, e.g. Copayments, Deductible or Coinsurance paid by you.

Covered Services - services, supplies or treatments which are:

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

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

Covered Transplant Procedures - any Medically Necessary human organ and stem cell/ bone marrow transplants and transfusions as listed as a Covered Services in this Benefit Booklet or as determined by Us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloblative therapy.

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

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

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

Dental Services – services, supplies, appliances and related expenses for treatment of conditions related to the teeth or structures supporting the teeth, or for improving dental clinical outcomes.

Dependent - a Subscriber's legal Spouse, Common Law Spouse, same sex domestic partner or child as defined in the **MEMBERSHIP** section of this Benefit Booklet under the heading **Dependents**.

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

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

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

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

Effective Date - the date coverage under this Benefit Booklet begins.

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

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

Employer – the City and County of Broomfield located in Broomfield, Colorado.

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

Experimental/Investigational -

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

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

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

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

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

- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes

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

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

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

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

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

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

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

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

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

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

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

Home Health Agency - an agency certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal "Social Security Act" as amended, for Home Health Agencies. A Home

Health Agency is primarily engaged in arranging and providing nursing services, home health aide services, and other therapeutic and related services.

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

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

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

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

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

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

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

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

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

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

Inpatient Rehabilitation 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 Inpatient Rehabilitation Therapy may be received from an acute rehabilitation facility, Skilled Nursing Care 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 generally accepted course of medical practice no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area, system or organ of the body perceived as the source of the pain.

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

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

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

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

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

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

Maximum Allowable Amount - The maximum amount that We determine is the maximum amount payable for Covered Services you receive, up to but not to exceed charges actually billed. Our determination considers:

- Amounts charged by other Providers for the same or similar service;
- Any unusual medical circumstances requiring additional time, skill or experience; and/or
- Other factors We determine are relevant, including but not limited to, a resource based relative value scale;
- The amount accepted by a In-Network Provider as payment in full under the participation agreement for this product.

For an In-Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the In-Network Provider's participation agreement for this product. If an In-Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount.

For an Out-of-Network Provider who is a Physician or other non-Facility Provider, even if the Provider has a participation agreement with Us for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with In- Network Providers for this Product.

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

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

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury
- Obtained from a Physician and/or licensed, certified or registered Provider
- Provided in accordance with applicable medical and/or professional standards
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes
- The most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient)
- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of your illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- Not Experimental/Investigational
- Not primarily for you, your families, or your Provider's convenience
- Not otherwise subject to an exclusion under this Benefit Booklet

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

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

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

Mental Health Condition - mental conditions, including without limitation, biologically based mental illness, that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (e.g., depression secondary to diabetes or primary depression). Mental Health Condition shall not include autism.

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

OB/GYN (Obstetrics and/or Gynecology) – a Provider specializing in obstetrical and gynecology services.

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

Open Enrollment – the annual period, determined by the Employer during which you may enroll yourself and your Dependents for coverage or change coverage options, if this option is available.

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

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

Osteopathic Manipulative Therapy (OMT) - correction by manual or mechanical means for structural imbalance or sublaxation to remove nerve interference from or related to distortion, misalignment or sublaxation of or in the vertebral column.

Out-of-Network - a term for Providers or facilities that do not enter into a network agreement with Us. Services received from an Out-of-Network Provider are limited to Emergency and Urgent Care only, unless Authorized by Us or included in Special Services.

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

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

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

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

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

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

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

Prescription Drugs - Prescription Drugs include:

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

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

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

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

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

Pharmacy - an establishment licensed to dispense Prescription Drugs by a licensed pharmacist upon a licensed health care professional's order. A Pharmacy may be an In-Network Provider or an Out-of-Network Provider. An In-Network Pharmacy is contracted as an In-Network Pharmacy with Us to provide covered drugs to you under the terms and conditions of this Benefit Booklet. An Out-of-Network Pharmacy is **not** contracted with Us.

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

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

Prescription Drug Maximum Allowed Amount - the maximum amount We allow for any Prescription Drug. The amount is determined by Us using prescription drug costs information provided to Us by the Pharmacy Benefits Manager (PBM).

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

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

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

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

Provider - a person or facility that is recognized by Us as a health care In-Network Provider or is a Provider who We have authorized and fits one or more of the following descriptions:

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

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

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

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

- **Primary Care Providers (PCP) -** is typically an internal medicine Physician, family practice Physician, general practitioner, or pediatrician who has contracted with Us to supervise, coordinate and provide initial and basic care. While you need to select a PCP, if you choose to see a PCP who is not your selected PCP they will be subject to the lower PCP copayment. For the application of the Member's Cost Sharing an OB/GYN will be treated as a PCP, however the Member cannot select an OB/GYN as his or her Primary Care Provider.

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

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

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

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

Reconstructive Surgery - in this Benefit Booklet Reconstructive Surgery includes those procedures that are intended to address a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or Congenital Defect.

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

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

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

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

Routine Patient Care (associated with clinical trials) - all items and services that are a Covered Service under this Benefit Booklet that would be covered if the Member was not involved in either the experimental or the control arms of a clinical trial. However, such care does not include: items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; routine costs in clinical trials that include items or services that are typically provided absent a clinical trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

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

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

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

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

Specialist - a professional, usually a Physician, devoted to a specific disease, condition or body part. Examples include, but are not limited to psychiatrist, orthopedist and cardiologist.

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

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

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

Spouse - a Subscriber's legal, Common Law Spouse or same sex domestic partner..

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

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

Sub-Acute Rehabilitation - Inpatient Rehabilitation Therapy that has a duration in-between acute (short-term) and chronic (long-term) and includes a minimum of one hour of rehabilitation therapy per day.

Subcontractor – We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs and Mental Health and Alcohol Dependency or

Substance Dependency services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer services duties on Our behalf.

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

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

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

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

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

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

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

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

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

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

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

VISION EXAM COVERAGE

We are pleased to welcome you as a Member of an Anthem Blue Cross and Blue Shield **Group Vision Plan**. This Membership Benefit Booklet is a guide to your coverage.

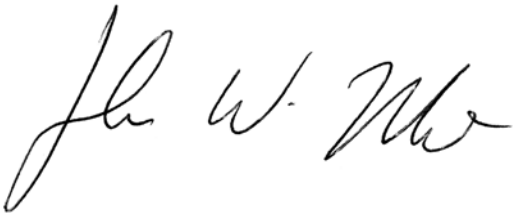
This Benefit Booklet has been prepared by Us to help explain your vision care coverage. Please refer to this Benefit Booklet whenever you require vision services. It describes how to access vision care and what vision services are covered by Us. See your Blue View Vision Summary of Benefits to determine what portion of the vision costs you will be required to pay.

The coverage described in this Benefit Booklet is subject in every respect to the provisions of the BlueAdvantage HMO Benefit Booklet.

Many words used in the Vision Benefit Booklet have special meanings and are unique to the Vision coverage. These words appear in capitals and are defined for you. Refer to these definitions in the **Definitions** section for the best understanding of what is being stated.

This Benefit Booklet also contains **Exclusions,** so please read your Benefit Booklet carefully.

An additional benefit of your vision coverage is the backing of Anthem Blue Cross and Blue Shield.



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

INTRODUCTION

Services and Benefits

If your care is rendered by a Network Provider, benefits will be provided at the Network level. Refer to the Summary of Benefits. No benefits will be provided for care that is not a Covered Service even if performed by a Network Provider.

Network Services

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

Non-Network Services

Services which are not obtained from a Network Provider will be considered a Non-Network Service. In addition, certain services may not be covered unless obtained from a Network Provider, and/or may result in higher cost-share amounts. See your Blue View Vision Summary. You may be required to file claims for Covered Services you obtain directly from a Non-Network Provider.

Relationship of Parties (Plan - Network Providers)

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

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

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

Not Liable for Provider Acts or Omissions

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

DEFINITIONS

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

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

NOTE: "We," "Our," and "Us" refer to Anthem Blue Cross and Blue Shield or Anthem BCBS.

Copayment - A specific dollar amount or percentage of the Maximum Allowable Amount for Covered Services indicated in the Summary of Benefits for which you are responsible.

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

- Specifically included as a benefit under this Benefit Booklet;
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Benefit Booklet is in force;
- Not otherwise excluded or limited by the Benefit Booklet, or by any amendment or rider thereto.
- Authorized in advance by Us if such Preauthorization is required in the Benefit Booklet.

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

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

For a Network Provider, the Maximum Allowable Amount is equal to the amount that constitutes payment in full under the Network Provider's participation agreement for this product. If a Network Provider accepts as full payment an amount less than the negotiated rate under the participation agreement, the lesser amount will be the Maximum Allowable Amount.

For a Non-Network Provider who is a Physician or other non-facility Provider, even if the Provider has a participation agreement with Us for another product, the Maximum Allowable Amount is the lesser of the actual charge or the standard rate under the participation agreement used with Network Providers for this product. We will reimburse up to the Non-Par Reimbursement schedule identified in the Summary of Benefits.

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

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

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

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

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

WHAT WE WILL PAY FOR — BENEFITS

This section describes the Covered Services available under your vision care benefits when provided and billed by Network Providers. All Covered Services are subject to the exclusions listed in the **General Limitations and Exclusions** section and all other conditions and limitations of the Benefit Booklet. The amount payable for Covered Services varies depending on whether you receive your care from a Network Provider or a Non-Network Provider and whether or not you choose optional services and/or custom materials rather than standard services and supplies. Payment amounts are specified in the Blue View Vision Summary.

The following are Covered Services:

- Vision examination – one per calendar year per Member

Services obtained through a Non-Network Provider are subject to the same exclusions and limitations as services through a Network Provider.

WHAT WE WILL NOT PAY FOR — GENERAL LIMITATIONS AND EXCLUSIONS

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining benefits of services or supplies.

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

- Eyeglass Frames
- Eyeglass Lenses
- Elective or Non-Elective Contact Lenses
- Orthoptics or vision training and any supplemental testing
- Plano (non- prescription) lenses
- Medical or surgical treatment of the eyes under the Vision rider; however, may be covered subject to plan provisions under the medical coverage
- An eye exam or corrective eyewear required by an employer as a condition of employment
- Any injury or illness covered under Workers' Compensation or similar law, or which is work related
- Sub-normal vision aids
- Plain or prescription sunglasses or tinted lenses, and no-line bifocals and blended lenses
- Charges in excess of Usual and Customary for services and material
- Experimental or non-conventional treatments or devices
- Safety eyewear
- In conjunction with other offers or discounts
- Spectacle lens styles, materials, treatments or "add-ons" not shown in the Blue View Vision Summary

HOW TO FILE CLAIMS AND APPEALS

This section explains how to file claims in order to obtain benefits, and what to do if you disagree with the action taken on your claim.

How to File Claims

When a Network Provider bills Us for Covered Services, We will pay them the appropriate benefit directly to the provider. Payment is subject to any applicable Copayment requirements.

If a Non-Network Provider does not bill Us directly, you must file your own claim. You must use the claim form that is available at www.anthem.com or call Our customer service department for information on how to obtain the claim form. Attach the invoice from the Provider and include your Member number on the claim form. Balance due statements, cash register receipts, and cancelled checks are not acceptable. All information on the receipt must be readable. If information is missing on your invoice or is not readable, it will be returned to you.

We pay the benefits of this Benefit Booklet directly to Network Providers. A list of Network Providers is available upon request. We pay the benefits of this Benefit Booklet directly to Non-Network Providers, if you have authorized assignment of benefits. We may require a copy of the assignment of benefits for Our records. These payments fulfill Our obligation to you for these services.

Where and When to Send Your Claim

Make copies of the bills for your own records and attach the original bills to the claim form. Submit the claim form to:

Blue View Vision
OON Claims
P.O Box 8504
Mason, OH 45040-7111

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