Anthem BlueCross BlueShield

SECTION 1. SUMMARY OF BENEFITS (Who Pays What)

Anthem

Anthem Silver PPO 4000/15%

January 1, 2016

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

PART B: SUMMARY OF BENEFITS

This summary identifies Deductible, Copayment and Co-insurance options that the Member will pay, and a brief description of Covered Services. For benefit exclusions and limitations, please read the LIMITATION/EXCLUSIONS (WHAT IS NOT COVERED) section of the policy.

This Summary of Benefits does not explain in detail the benefits, exclusions, limitations, Deductibles or Out of Pocket Maximums. For a complete explanation, You should read Your whole Booklet to know the terms of Your coverage because many parts are related. Therefore, reading just one or two sections may not give You a full understanding of Your coverage.

Reimbursement for Covered Services is based on the Maximum Allowed Amount, which is the most Your Booklet will allow for a Covered Service. For more complete information, see Your Booklet or call the Customer Service Department phone number on the back of Your Identification Card.

What will I pay?

The Deductible applies to all Covered Services with a Copayment and/or Coinsurance, including 0% Coinsurance, except for:

- In-Network Preventive Care Services required by law
- Pediatric Vision Services
- Services, listed in the chart below, that specifically indicate that the Deductible does not apply

For Out-of-Network Providers, You will always be responsible for the difference between Maximum Allowed Amount and the Billed Charges even if You have reached the Out-of-Network Out-of- Pocket Annual Maximum.

4A. DEDUCTIBLE TYPE	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
Deductible Type[2]	Calendar Year	Calendar Year

4B. ANNUAL DEDUCTIBLE	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
a) Individual	$4,000 per Benefit Period	$10,000 per Benefit Period
b) Family	$8,000 per Benefit Period	$20,000 per Benefit Period
The individual Deductible applies to each covered family member. No one person can contribute more than their individual Deductible amount. Once two or more covered family members' deductibles combine to equal the family Deductible amount, the Deductible will be satisfied for the family for that calendar year. Please see SECTION 9. MEMBER PAYMENT RESPONSIBILITY for more details.		

5. OUT-OF-POCKET ANNUAL MAXIMUM	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
a) Individual	$6,850 per Benefit Period	$17,125 per Benefit Period
b) Family	$13,700 per Benefit Period	$34,250 per Benefit Period
c) Is Deductible included in the Out-of-Pocket Annual Maximum?	Yes	Yes
The individual Out-of-Pocket Annual Maximum applies to each covered family member. Once two or more covered family members' Out-of-Pocket Annual Maximum combine to equal the family Out-of-Pocket Annual Maximum amount, the Out-of-Pocket Annual Maximum will be satisfied for the family for that calendar year. No one person can contribute more than their individual Out-of-Pocket Annual Maximum. Some Covered Services have a maximum numbers of days, visits or dollar amounts allowed. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied. The Out-of-Pocket Annual Maximum does not include charges over the Maximum Allowed Amount or amounts for non-covered services. Please see SECTION 9. MEMBER PAYMENT RESPONSIBILITY for more details.		

6A. COVERED PROVIDERS	IN-NETWORK	OUT-OF-NETWORK
Covered Providers	Anthem PPO network. Go to the directory of In-Network Providers at www.anthem.com for the lists of Providers that participate in the network.	All Providers licensed or certified to provide covered benefits.

6B. PROVIDERS	IN-NETWORK	OUT-OF-NETWORK
With respect to network plans, are all the providers listed in 6A accessible to me through my primary care physician?	Yes	Yes

7. PHYSICIAN VISITS [3]	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
a) Physician office visits, Physician consultations, Primary Care Provider (PCP) Telemedicine, and Retail Health Clinic	$45 Copayment. Deductible does not apply. 0% Co-insurance	$0 Copayment 50% Co-insurance
b) Specialists, Online Visits, Specialist Telemedicine, and Inpatient/ Outpatient	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance
c) Other office services	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance

8. PREVENTIVE CARE	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
Preventive care	No charge - (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; and are not subject to Deductible, Copayments and/or Co-	$0 Copayment 50% Co-insurance

	insurance. Please see the Preventive Care Services section in Your Booklet for a full description of covered preventive care services.	

9. MATERNITY	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
a) Physician visits	Covered under Physician Visits. See Section 7 for payment information.	Covered under Physician Visits. See Section 7 for payment information.
b) Delivery & inpatient well baby care[4]	Covered under Inpatient Hospital. See Section 11 for payment information.	Covered under Inpatient Hospital. See Section 11 for payment information.

10. PRESCRIPTION DRUGS[5]	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
Retail Pharmacy (up to a 30 day supply)	• **Tier 1:** $15 Copayment. Deductible does not apply. 0% Co-insurance	• **Tier 1:** $0 Copayment 50% Co-insurance
	• **Tier 2:** $40 Copayment. Deductible does not apply. 0% Co-insurance	• **Tier 2:** $0 Copayment 50% Co-insurance
	• **Tier 3:** $80 Copayment. Deductible does not apply. 0% Co-insurance	• **Tier 3:** $0 Copayment 50% Co-insurance
	• **Tier 4:** $500 Copayment. Deductible does not apply. 0% Co-insurance	• **Tier 4:** Not Covered
Mail Order (up to a 90 day supply, except for Tier 4)	• **Tier 1:** $30 Copayment. Deductible does not apply. 0% Co-insurance	• **Tier 1:** Not Covered

	• **Tier 2:** $100 Copayment. Deductible does not apply. 0% Co-insurance	• **Tier 2:** Not Covered
	• **Tier 3:** $200 Copayment. Deductible does not apply. 0% Co-insurance	• **Tier 3:** Not Covered
	• **Tier 4:** Not Covered	• **Tier 4:** Not Covered
	At least one product in all 18 approved methods of contraception is covered under this policy without Cost Sharing as required by federal and state law.	

11. INPATIENT HOSPITAL	**IN-NETWORK Member Pays**	**OUT-OF-NETWORK Member Pays**
Inpatient Hospital	$500 Copayment per admission 15% Co-insurance	$500 Copayment per admission 50% Co-insurance
	Inpatient rehabilitation services are limited to total of two months of therapy per Benefit Period.	

12. OUTPATIENT/ AMBULATORY SURGERY	**IN-NETWORK Member Pays**	**OUT-OF-NETWORK Member Pays**
Outpatient/ ambulatory Surgery	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance

13. DIAGNOSTIC SERVICES; OUTPATIENT	**IN-NETWORK Member Pays**	**OUT-OF-NETWORK Member Pays**
a) Diagnostic laboratory and pathology services	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance

b) Diagnostic imaging services and electronic diagnostic tests	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance
c) Advanced imaging services	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance

14. EMERGENCY CARE[6, 7]	**IN-NETWORK Member Pays**	**OUT-OF-NETWORK Member Pays**
Emergency care	$500 Copayment per Emergency Room visit 15% Co-insurance Emergency Room Copayment is waived if admitted.	$500 Copayment per Emergency Room visit 15% Co-insurance Emergency Room Copayment is waived if admitted. Cost Shares paid for Out-of-Network Emergency care, including Emergency medical transportation (ambulance) and Emergency Hospital care, will apply to the In-Network Deductible.

15. AMBULANCE (Ground, Air, & Water)	**IN-NETWORK Member Pays**	**OUT-OF-NETWORK Member Pays**
a) Emergency	$0 Copayment 15% Co-insurance	$0 Copayment 15% Co-insurance
b) Non-Emergency	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance
	Air Ambulance services for non-Emergency Hospital to Hospital transfers must be approved through precertification. All scheduled ground Ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Benefits for non-Emergency ambulance services will be limited to $50,000 per occurrence if an Out-of-Network Provider is used and will be subject to Out-of-Network Provider Cost Shares.	

16. URGENT, NON-ROUTINE AFTER HOURS CARE	**IN-NETWORK Member Pays**	**OUT-OF-NETWORK Member Pays**

Urgent, non-routine after hours care	$50 Copayment 15% Co-insurance	$50 Copayment 15% Co-insurance

17. MENTAL HEALTH CARE AND SUBSTANCE ABUSE	**IN-NETWORK Member Pays**	**OUT-OF-NETWORK Member Pays**
a) Inpatient Facility (including Residential Treatment)	$500 Copayment per admission 15% Co-insurance	$500 Copayment per admission 50% Co-insurance
b) Outpatient Facility (including partial hospitalization or intensive outpatient)	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance
c) Outpatient office	Covered under Physician Visits. See Section 7 for payment information.	Covered under Physician Visits. See Section 7 for payment information.

18. PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY	**IN-NETWORK Member Pays**	**OUT-OF-NETWORK Member Pays**
Physical, occupational and speech therapy	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance
	Up to 20 visits each for physical, occupational or speech therapy per Benefit Period. Limit applies to rehabilitation services. From birth until the Member's sixth birthday, benefits are provided as required by applicable law. In addition, up to 20 visits each for physical, occupational or speech therapy per Benefit Period. Limit applies to habilitation services. From birth until the Member's sixth birthday, benefits are provided as required by applicable law.	

19. DURABLE MEDICAL EQUIPMENT	**IN-NETWORK Member Pays**	**OUT-OF-NETWORK Member Pays**
Durable Medical Equipment	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance

20. OXYGEN	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
Oxygen	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance

21. ORGAN TRANSPLANTS	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
Organ transplants	Cost-share(s) determined based on type of service and where services are rendered.	Cost-share(s) determined based on type of service and where services are rendered.
	Out-of-Network Out-of-Pocket Annual Maximum does not include amounts You pay for Out-of-Network Human Organ and Tissue Transplant Services. See Your Booklet for details on covered transplants.	

22. HOME HEALTH CARE	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
Home Health Care	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance
	We will pay benefits up to a maximum of 28 hours per week.	

23. HOSPICE	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
Hospice	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance

24. SKILLED NURSING FACILITY CARE	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
Skilled Nursing Facility Care	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance
	We will cover up to 100 days per Benefit Period.	

25. SIGNIFICANT ADDITIONAL COVERED SERVICES	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays

Significant additional Covered Services	$0 Copayment 15% Co-insurance	$0 Copayment 50% Co-insurance
	Hearing Aids Hearing aids are covered up to age 18 and are supplied every 5 years, except as required by law. **Treatment of Autism Spectrum Disorders** Benefit level determined by type of service provided. The following maximums are effective for applied behavior analysis services, however, we may exceed these maximums as required by law: • Birth to age 8: 550 sessions, 25 minutes in length. • Age 9-19: 185 sessions, 25 minutes in length. **Early Intervention Services** 45 visits per Benefit Period.	

PART C: LIMITATIONS AND EXCLUSIONS

LIMITATIONS AND EXCLUSIONS	IN-NETWORK	OUT-OF-NETWORK
26. What treatments and conditions are excluded under this policy?	Exclusions vary by policy. A list of exclusions is available immediately upon request from Your carrier, agent, or plan sponsor, if any. Review the list to see if a service or treatment You may need is excluded from the policy.	Exclusions vary by policy. A list of exclusions is available immediately upon request from Your carrier, agent, or plan sponsor, if any. Review the list to see if a service or treatment You may need is excluded from the policy.

PART D: USING THE PLAN

USING THE PLAN	IN-NETWORK	OUT-OF-NETWORK
27. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No. Care from these Providers can be received without a referral from participating Providers within the Anthem PPO network.	No. Care from these Providers can be received without a referral from participating Providers within the Anthem PPO network.

USING THE PLAN	IN-NETWORK	OUT-OF-NETWORK
28. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the Doctor who schedules the procedure or Hospital care is responsible for obtaining the Preauthorization.	Yes, the Member is responsible for obtaining the Preauthorization.

USING THE PLAN	IN-NETWORK	OUT-OF-NETWORK
29. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes

USING THE PLAN	IN-NETWORK	OUT-OF-NETWORK
30. What is the main customer service number?	Call the Customer Service phone number on the back of Your Identification Card.	Call the Customer Service phone number on the back of Your Identification Card.

USING THE PLAN	IN-NETWORK	OUT-OF-NETWORK
31. Whom do I write/call if I have a complaint or want to file a grievance?	Anthem Member Appeals Department 700 Broadway Mail Stop CO0104-0430 Denver, CO 80273 Call the Customer Service phone number on the back of Your Identification Card.	Anthem Member Appeals Department 700 Broadway Mail Stop CO0104-0430 Denver, CO 80273 Call the Customer Service phone number on the back of Your Identification Card.

USING THE PLAN	IN-NETWORK	OUT-OF-NETWORK
32. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance Attention ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	Write to: Colorado Division of Insurance Attention ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202

USING THE PLAN	IN-NETWORK	OUT-OF-NETWORK
33. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form No.: CO_OFFHIX_PP_(1/16)	Policy form No.: CO_OFFHIX_PP_(1/16)

USING THE PLAN	IN-NETWORK	OUT-OF-NETWORK
34. Does the plan have a binding arbitration clause?	Yes	Yes

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

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

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

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

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

[6] "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.

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

PART E: PEDIATRIC VISION SERVICES

We cover the following vision care services for Members to the end of the month in which they turn age 19.

Coverage is only provided when services are received from Blue View Vision Provider. Out-of-Network providers may bill You for any charges that exceed the plan's maximum allowed amount. Visit Our website or call the Blue View Vision number on Your ID card for help in finding a provider. Covered Vision Services are **not** subject to the Calendar Year Deductible.

PEDIATRIC VISION CARE	IN NETWORK Member Copayment/Allowance	OUT-OF-NETWORK Member Reimbursement
Routine Eye Exam	$0 Copayment	$30 Allowance
Once every calendar Year		
Standard Plastic Lenses*		
Once every calendar Year Available only if contact lens benefit is not used.		
Single Vision	$0 Copayment	$25 Allowance
Bifocal	$0 Copayment	$40 Allowance
Trifocal	$0 Copayment	$55 Allowance
Progressive	$0 Copayment	$40 Allowance
Lens options include factory scratch coating, UV coating, standard polycarbonate and standard photochromic lenses at no additional cost when received In-Network.		
Frames* (vision formulary) This plan offers a selection of covered frames.	$0 Copayment	$45 Allowance
Once every calendar Year		
Contact Lenses* (vision formulary) This plan offers a selection of covered contact lenses. Available only if the eyeglass lens benefit is not used.		

Elective Contact Lenses	$0 Copayment	$60 Allowance
Non-Elective Contact Lenses	$0 Copayment	$210 Allowance
Once every calendar Year		

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed in this Summary of Benefits.

PART F: PEDIATRIC DENTAL SERVICES

We cover the following dental care services for Members to the end of the month in which they turn age 19, except as specifically provided in the benefit booklet. This policy is being offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. If you want adult dental benefits, you will need to buy a plan that has adult dental benefits. Except as stated in the benefit booklet, this plan will not pay for any adult dental care, so you will have to pay the full price of any care you receive.

The following dental benefits are available as Covered Services from an In-Network and Out-of-Network dentist. Please see the Dental Services section of Your Booklet for a full description of covered Pediatric dental services.

PEDIATRIC DENTAL CARE	IN-NETWORK Member Pays	OUT-OF-NETWORK Member Pays
Diagnostic & Preventive Services	10% Co-insurance	30% Co-insurance
Basic Restorative Services	50% Co-insurance	50% Co-insurance
Endodontic Services	50% Co-insurance	50% Co-insurance
Periodontal Services	Not Covered	Not Covered
Oral Surgery Services	50% Co-insurance	50% Co-insurance
Major Restorative Services	50% Co-insurance	50% Co-insurance
Prosthodontic Services	Not Covered	Not Covered
Dentally Necessary Orthodontic Care	50% Co-insurance	50% Co-insurance
Cosmetic Orthodontic Care	Not Covered	Not Covered

IMPORTANT: You are responsible for confirming that the Provider You are seeing or have been referred to see is an In-Network Provider for this plan. It is important to understand that Anthem has many contracting Providers who may not be part of the network of Providers that applies to this plan.

Anthem can help You find an In-Network Provider specific to Your Plan by calling the number on the back of your identification card.

SECTION 2. TITLE PAGE (Cover Page)

Anthem Silver PPO 4000/15%

Anthem

Anthem BlueCross BlueShield

SECTION 3. CONTACT US

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

Please review this document to become familiar with Your benefits, including what is not covered. By learning how coverage works, You can help make the best use of Your benefits.

For questions about coverage, please visit Our website or call Our Member services department. The website address is www.anthem.com and the toll-free Member services number is located on the Summary of Benefits section found in this Booklet or the Identification Card mailed to Your home.

Ten days to review

If this Booklet is provided to You as a new Subscriber, You have 10 days to review this Booklet to make sure that You are satisfied with the product You selected. If You are not satisfied, return this Booklet along with a letter to let Us know that You are not satisfied within 10 days after You receive it. Any Premium paid will be refunded to You, less any amounts paid in claims for You.

Thank You for selecting Us for Your health care coverage. We wish You good health.

Mike Ramseier
President and General Manager
Anthem

How to Get Language Assistance

Anthem is committed to communicating with Our Members about their health plan, no matter what their language is. We employ a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of Your Identification Card and a representative will be able to help You. Translation of written materials about Your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with Your needs.

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

(If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number.)

Contact Us

Customer service phone number

Please call the Customer Service phone number at 1 (855) 383-7249

Customer service mailing address

Anthem Blue Cross and Blue Shield
Customer Service Department
P.O. Box 5747
Denver, CO 80217-5747

Visit Us on-line

www.anthem.com

Hours of operation

Monday - Friday
7:30 a.m. to 6:30 p.m. MST

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

Health benefit coverage is defined in the following documents:

- This Booklet, the Summary of Benefits and any amendments to it.
- The Colorado Individual Enrollment Application form and any other application from You or Your Dependents; and
- Your Identification Card.

Anthem, or someone on Our behalf, will determine how benefits will be managed and who is eligible under this Booklet. If any question comes up about any terms of this Booklet, or how they are applied, Our determination will be final. This may include questions of whether the services, care, treatment, or supplies are Medically Necessary, Experimental or Investigational, or Cosmetic. However, a Member may utilize all applicable appeals and complaints procedures available under this Booklet.

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

Acknowledgement of Understanding

Subscriber hereby expressly acknowledges its understanding this certificate constitutes a contract solely between Subscriber and Anthem, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Us to use the Blue Cross and/or Blue Shield Service Mark(s) in the State of Colorado, and that Anthem is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this policy based upon representations by any person other than Anthem and that no person, entity, or organization other than Anthem shall be held accountable or liable to Subscriber for any of Anthem's obligations to Subscriber created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this certificate.

Anthem Blue Cross and Blue Shield & HMO Colorado Disclosure

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

Pursuant to Colorado law (C.R.S §10-16-201.5), this coverage is renewable at your option, except for the following reasons:

1. Non-payment of the required premium;
2. Fraud or intentional misrepresentation of material fact on the part of the Subscriber;
3. The commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations;
4. The carrier elects to discontinue offering and non-renew all of its individual plans delivered or issued for delivery in Colorado.

Cancer Screenings

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

Pap Tests

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

Mammogram Screenings

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

Prostate Cancer Screenings

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

Colorectal Cancer Screenings

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

The information above is only a summary of the benefits described. The Booklet for each health plan includes important additional information about limitations, exclusions and covered benefits. The Colorado Summary of Benefits for each health plan includes additional information about Copayments, Deductibles and Coinsurance. If you have any questions, please call the Customer Service phone number on the back of Your Identification Card.

Member Rights and Responsibilities

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

You have the right to:

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

You have the responsibility to:

- Read all information about Your health benefits and ask for help if You have questions.
- Follow all health plan rules and policies.
- Choose an In-network primary care physician, also called a PCP, if Your health plan requires it.
- Treat all doctors, health care Providers and staff with respect.
- Keep all scheduled appointments. Call Your health care Provider's office if You may be late or need to cancel.
- Understand Your health problems as well as You can and work with Your health care Providers to make a treatment plan that You all agree on.
- Inform Your health care Providers if You don't understand any type of care You're getting or what they want You to do as part of Your care plan.
- Follow the health care plan that You have agreed on with Your health care Providers.
- Give us, Your doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are eligible for under Your health plan. This may include information about other health insurance benefits You have along with Your coverage with us.
- Inform Member Services if You have any changes to Your name, address or family Members covered under Your Booklet.

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

We want to provide high quality benefits and customer service to Our Members. Benefits and coverage for services given under the plan are overseen by Your Certificate of Coverage, Member Handbook or Schedule of Benefits and not by this Member Rights and Responsibilities statement.

SECTION 4. TABLE OF CONTENTS

SECTION 5. ELIGIBILITY

Eligibility

Subscriber

To be eligible for membership as a Subscriber under this Booklet, the applicant must:

1. Be a United States citizen or national; or
2. Be a legal resident of Colorado;
3. Submit proof satisfactory to Anthem to confirm Dependent eligibility;
4. Agree to pay for the cost of Premium that We require;
5. Not be incarcerated (except pending disposition of charges);
6. Not be entitled to or enrolled in Medicare;
7. Not be covered by any other group or individual health policy.

For purposes of Eligibility, You will be considered to reside in the Service Area if You:

1. Reside, intend to reside (including without a fixed address) in the Service Area; or
2. Are seeking employment (whether or not currently employed) in the Service Area; or
3. Have entered the Service Area without a job commitment.

Dependents

To be eligible for coverage to enroll as a Dependent, You must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria and be:

1. The Subscriber's legal Spouse.
2. The Subscriber's Domestic Partner – Is a person, other than a spouse, with whom one cohabits. A Domestic Partner is only eligible for coverage if: he or she has been the Subscriber's sole Domestic Partner for 12 months or more; is mentally competent; is at least 18 years old; is not related to the Subscriber in any way (including by blood or adoption) that would prohibit marriage under State law; is not married to or separated from anyone else; and is financially interdependent with the Subscriber:

    - Except as specifically provided in Booklet, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    - A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    - To apply for coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign a Colorado Individual Enrollment Application, meet all criteria stated on the application and submit the application to Us. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

3. The Subscriber's or the Subscriber's Spouse's children, including stepchildren, newborn and legally adopted children under age 26.
4. Children under age 26 for whom the Subscriber or the Subscriber's Spouse is a permanent legal guardian.

Eligibility will be continued past the age limit only for those already enrolled Dependents who are medically certified as disabled and are dependent upon the parent Subscriber. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Booklet must certify the Dependent's eligibility. We must be informed of the Dependent's eligibility for

continuation of coverage within 30 days after the date Dependent would normally become ineligible. You must notify Us if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

We may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Booklet.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Booklet unless required by the laws of this State.

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in this plan, and Members may change benefit plans at that time.

The open enrollment period for the following year begins October 15 and extends through December 7 of the current year.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in this Booklet, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Member or enrollee has 60 calendar days from the date of a qualifying event to select a Policy.

If an individual is notified or becomes aware of a qualifying event that will occur in the future, he or she may apply for coverage during the thirty (30) calendar days prior to the effective date of the qualifying event, with coverage beginning no earlier than the day the qualifying event occurs to avoid a gap in coverage. The individual must be able to provide written documentation to support the effective date of the triggering event at the time of application.

Qualifying Events:

- An individual involuntary loses Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay Premium;
- Loss of Minimum Essential Coverage due to dissolution of marriage; termination of a recognized domestic partnership; or termination of a recognized civil union;
- An individual gains a dependent or becomes a dependent through marriage, civil union, birth, adoption, or placement for adoption, placement in foster care or by entering into a designated beneficiary agreement pursuant to Article 22 of Title 15, C.R.S;
- The Exchange, established in accordance with applicable State law, determines an individual to be newly eligible or newly ineligible for the Federal Advance Payment Tax Credit or cost-sharing reductions available through the Exchange pursuant to federal law;
- An individual gains access to other coverage as a result of a permanent change of residence;
- Any other event or circumstance occurs as set forth in rules established by applicable State law in defining triggering events.

Newborn and Adopted Child Coverage

A newborn child of the Subscriber or the Subscriber's Spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits to Us a form to add the child under the Subscriber's Booklet. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child. A child will be considered adopted from the earlier of: (1) the moment of

placement for adoption; or (2) the date of an entry of an order granting custody of the child to You. The placement begins when You assume or retain a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates at the time such legal obligation terminates. The child will continue to be considered adopted unless the child is removed from Your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Legal Guardianship

If a Subscriber or the Subscriber's Spouse files an application for an appointment of permanent legal guardianship for a child, an application to cover the child under the Subscriber's Booklet must be submitted to Us within 60 days of the date of the appointment of legal guardianship. Coverage will be effective on the date the appointment of legal guardianship is awarded by the court.

Qualified Medical Child Support Order

If You are required by a Qualified Medical Child Support Order or court order, as defined by applicable State or federal law, to enroll Your child under this Booklet, and the child is otherwise eligible for the coverage, We will permit Your child to enroll under this Booklet, and We will provide the benefits of this Booklet in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit. Any claims payable under this Booklet will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Period. The actual Effective Date is determined by the date We receive a complete application with the applicable Premium payment.

Effective Dates for Special Enrollment periods:

1. In the case of birth, adoption or placement for adoption, and placement in foster care coverage is effective on the date of birth, adoption, placement for adoption or placement in foster care; and
2. In the case of marriage, civil union or in the case where an individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after Your application is received.

Loss of minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation, dissolution of Domestic Partnership or recognized civil union, or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage after a period that is measured by reference to any of the following:
    - Individual, who no longer resides, lives or works in the prior plan's Service Area.
    - A situation in which the prior plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.
    - Termination of employer contributions, and
    - Exhaustion of COBRA or state continuation benefits.

There is no Special Enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

1. Failure to pay Premiums on a timely basis, including COBRA or state continuation Premiums prior to expiration of COBRA or state continuation coverage, or

2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify Us of any changes affecting the Subscriber's or Dependent(s) eligibility for services or benefits under this Booklet. We must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Individual Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Individual Coverage. We must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Individuals seeking to enroll under this Booklet shall complete and submit Our applications or other forms or statements We may request. Individuals applying for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to Us is true, correct, and complete. Individuals applying for membership understand that all rights to benefits under this Booklet are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Booklet for each Subscriber.

Multiple Anthem Coverage

If a Member is covered under this Booklet and is also covered by another Anthem individual policy, the Member is limited to the one policy elected by the Member, the Member′s beneficiary or the Member's estate, as the case may be, and We will return all Premiums paid for all other such policies. However, We will deduct any benefits paid under the individual policy from the subscription charges being refunded.

SECTION 6. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

Introduction

Your plan is a PPO plan. The plan has two sets of benefits: In-Network and Out-of-Network. If You choose an In-Network Provider, You will pay less in out-of-pocket costs, such as Copayments, Deductibles, and Coinsurance. If You use an Out-of-Network Provider, You will have to pay more out-of-pocket costs.

In-Network Services

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

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers - SCPs), other professional Providers, Hospitals, and other Facilities who contract with Us to care for you. Referrals are never needed to visit an In-Network Specialist, including behavioral health Providers.

To see a Doctor, call their office:

- Tell them You are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask You for your group or Member ID number.
- Tell them the reason for your visit.

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

For services from In-Network Providers:

1) You will not need to file claims. In-Network Providers will file claims for Covered Services for you. (You will still need to pay any Coinsurance, Copayments, and/or Deductibles that apply.) You may be billed by your In-Network Provider(s) for any non-Covered Services You get or when You have not followed the terms of this Booklet.
2) Precertification will be done by the In-Network Provider.

We do not guarantee that an In-Network Provider is available for all services and supplies covered under your PPO plan. For some services and supplies We may not have arrangements with In-Network Providers. Please read the "Claims Procedure (How to File a Claim)" section for additional information on Authorized Services.

After Hours Care

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

Out-of-Network Services

When You do not use an In-Network Provider, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services from an Out-of-Network Provider:

1) In addition to any Deductible and/or Coinsurance/Copayments, the Out-of-Network Provider can charge You the difference between their bill and the plan's Maximum Allowed Amount;
2) You may have higher Cost Sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments);

3) You will have to pay for services that are not Medically Necessary;
4) You will have to pay for non-Covered Services;
5) You may have to file claims; and
6) You must make sure any necessary Precertification is done.

We will not deny or restrict Covered Services just because You get treatment from an Out-of-Network Provider; however, You may have to pay more.

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

How to Find a Provider in the Network

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

- Go to the directory of In-Network Providers at www.anthem.com, which lists the doctors, Providers, and Facilities that participate in Our network.
- Call Customer Service to ask for a list of doctors and Providers that participate in Our network, based on specialty and geographic area.
- Check with Your Doctor or Provider.

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

Identification Card

When You get care, You must show Your Identification Card. Only a Member who has paid the Premium for this coverage has the right to services or benefits under this Booklet. If anyone gets services or benefits which they are not allowed to receive under the terms of this Booklet, he/she must pay for the cost of the services.

Requesting Approval for Benefits

Your plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to You in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Preauthorization: Network Providers must obtain Preauthorization in order for You to get benefits for certain services. Preauthorization criteria will be based on many sources including medical policy, clinical guidelines, and Pharmacy and Therapeutics guidelines. We may decide that a service that was prescribed or asked for is not Medically Necessary if You have not first tried other Medically Necessary and more cost effective treatments.

If You have any questions about the information in this section, You may call the Customer Service phone number on the back of Your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. Precertification is not required for Emergent services; however You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable

period of time. For labor/childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check Your Booklet to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Booklet or is Experimental or Investigational as that term is defined in this Booklet.
- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental or Investigational nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Provider and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an In-Network Provider	**Services given by a BlueCard/Out-of-Network/Non-Participating Provider**
Provider	Member must get Precertification. If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. For Emergency admissions, precertification is not required. However, the Member, their authorized representative or doctor must tell Us within one business day of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventive care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigational as that term is defined in the Booklet otherwise. Your Booklet takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Preauthorization phone number on the back of Your Identification Card.

We may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, Case 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 Insured. 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 on-line Provider Directory, on-line pre-certification list, or contacting the Customer Service at number listed on Your Identification Card.

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

Request Categories

- **Expedited** – A request for Precertification or Predetermination that is in the view of the treating Physician or any Doctor with knowledge of Your medical condition, could without such care or treatment, seriously threaten Your life or health or Your ability to regain maximum function or subject You to severe pain that cannot be adequately managed without such care or treatment; or if You have a physical or mental disability, create an imminent and substantial limitation on Your existing ability to live independently.
- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on State and federal laws. Where State laws are stricter than federal laws, We will follow State laws. You may call the phone number on the back of Your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Expedited	72 hours from the receipt of request
Prospective Non-Expedited	15 calendar days from the receipt of the request
Continued Stay Review Expedited when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.

Continued Stay Review Expedited when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Expedited when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Expedited	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to You or Your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by State and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and You or Your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, precertification will consider:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under Your Booklet;
4) The service cannot be subject to an Exclusion under Your Booklet; and
5) You must not have exceeded any applicable limits under Your Booklet.

Health Plan Individual Case Management

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

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

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

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

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums

of this Booklet. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Us. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

SECTION 7. BENEFITS/COVERAGE

(What is Covered)

This section describes Covered Services and supplies. Services, supplies or treatments will be Covered Services if they are Medically Necessary or preventive, not otherwise excluded under this Booklet as determined by Us and obtained in the manner required by this Booklet. The Member can obtain care through an In-Network Physician or by self-referral to an In-Network Specialist including a behavioral health Provider. Additionally, all services must be provided and be within the 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 from Us.

We base Our decisions about Preauthorization, Medical Necessity, Experimental/Investigational and new technology on medical policy developed by Us. 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 exclusions listed in this section in addition to those set forth elsewhere in this Booklet including those in the GENERAL EXCLUSIONS section. All Covered Services are subject to other conditions and limitations of this Booklet. All Covered Services are subject to meeting Our medical policy criteria.

Allergy Services

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

Ambulance Services (Air, Ground and Water)

Medically Necessary Ambulance services are a Covered Service when one or more of the following criteria are met:

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

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

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

Out-of-Network Providers may bill You for any charges that exceed the plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to medical necessity review by Us. All scheduled ground Ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by Us. The Health plan retains the right to select the Air Ambulance Provider. This includes fixed wing, rotary wing or water transportation.

Air Ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air Ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground Ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air Ambulance is furnished when Your medical condition is such that transport by ground Ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air Ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air Ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water Ambulance Provider.

Autism Spectrum Disorders

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

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

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

Coverage of Autism Spectrum Disorders in BENEFITS/COVERAGE (WHAT IS COVERED) section is in addition to coverage provided for early intervention and Congenital Defects and Birth Abnormality. Autism services and the Autism Treatment plan are subject to Utilization Review.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to You as a participant in an approved Clinical Trial if the services are covered under this Booklet. An "approved Clinical Trial" means a phase I, phase II, phase III, or phase IV Clinical Trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an Investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the Investigational new drug application.

Your plan may require You to use an In-Network Provider to maximize Your benefits.

Routine patient care costs include items, services, and drugs provided to You in connection with an approved Clinical Trial and that would otherwise be covered by this plan.

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

Your plan is not required to provide benefits for the following services. We reserve Our right to exclude any of the following services

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

Dental Related Services

Accident-Related Dental Services

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

Treatment must begin within 90 days of the injury to be a Covered Service under this Booklet.

Cleft Palate and Cleft Lip Conditions

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

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

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

Dental Anesthesia for Children

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

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

Diabetes Equipment, Education, and Supplies

Your Booklet covers diabetes training and medical nutrition therapy if You have diabetes (whether or not it is insulin depended), or if You have raised blood glucose levels caused by pregnancy. Other medical conditions may also qualify. But the services need to be ordered by a Doctor and given by a Provider who is certified, registered or with training in diabetes. Diabetes training sessions must be provided by a Provider in an outpatient Facility or in a Doctor's office.

Screenings for gestational diabetes are covered under PREVENTIVE CARE SERVICES later in this section.

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services.

- Ultrasound.
- Electrocardiograms (EKG).
- Electroencephalography (EEG).
- Echocardiograms.
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care).
- Tests ordered before a Surgery or admission.

Advanced Imaging Services

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

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

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

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

Durable Medical Equipment and Medical Devices

Your plan includes benefits for Durable Medical Equipment and medical devices when the equipment meets the following criteria:

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

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

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

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for cochlear implants.

Hearing Aid Services

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

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

Orthotics

Benefits are available for certain types of Orthotics (braces, boots, splints). Covered Services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Prosthetics

Your plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are medically appropriate for and consistent with Your symptoms and proper treatment of Your condition, illness, disease or injury.

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

- Artificial limbs and accessories. For prosthetic arms and legs We cover up to the benefits amounts provide by federal laws for Medicare or where needed to meet State insurance laws.
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes.
- Breast prosthesis (whether internal or external) after a mastectomy, as required by applicable law.
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
- Restoration prosthesis (composite facial prosthesis).

Medical and Surgical Supplies

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

Blood and Blood Products

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

Emergency Care and Urgent Care

Emergency Services

Benefits are available in a Hospital Emergency room for services and supplies to treat the onset of symptoms, screen and Stabilize an Emergency, which is defined below:

Emergency (Emergency Medical Condition)

"Emergency" or "Emergency Medical Condition" means a medical condition that manifests itself by acute symptoms of sufficient severity, severe pain that a prudent layperson, with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:

(a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in jeopardy.

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

Emergency Care

"Emergency Care" means a medical exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical exams and treatment required to Stabilize the patient.

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

Medically Necessary services will be covered whether You get care from an In-Network or Out-of-Network Provider. Emergency Care You get from an Out-of-Network Provider will be covered as an In-Network service.

If You are admitted to the Hospital from the Emergency room, be sure that You or Your Doctor calls Us as soon as possible. We will review Your care to decide if a Hospital stay is needed and how many days You should stay. See HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS for more details. If You or Your Doctor do not call Us, You may have to pay for services that are determined to be not Medically Necessary.

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

Treatment You get after Your condition has Stabilized is not Emergency Care. If You continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless We agree to cover it as an Authorized Service.

Urgent Care Services

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

Benefits for Urgent Care include:

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

Home Health Care/Home Infusion (IV) Therapy

Home Health Care

This section describes Covered Services and exclusions for home health care and home infusion (IV) therapy. Benefits are provided for services performed by a Home Health Agency engaged in arranging and providing nursing services, home health aide services and other therapeutic services. Home Health Services are covered only when such services are necessary as alternatives to hospitalization. Prior hospitalization is not required. Home Health Services must be rendered pursuant to a Physician's written order, under a plan of care established by the Physician in collaboration with a Home Health Agency. We must preauthorize all services and reserves the right to review treatment plans at periodic intervals.

Covered Services include, but are not limited to the information listed below, and are allowed up to the maximum visits as listed on the Summary of Benefits per Member's Benefit Period:

- Professional nursing services performed by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N).
- Certified Nurse Aide services under the supervision of a Registered Nurse or a qualified therapist with professional nursing services.
- Physical Therapy provided by a licensed physical therapist.
- Occupational Therapy provided by a licensed occupational therapist or certified Occupational Therapy assistant.
- Respiratory and inhalation therapy services.
- Speech and hearing therapy and audiology services.
- Medical/social services.
- Medical Supplies (including respiratory supplies), Durable Medical Equipment (rental or purchase), oxygen, appliances, prostheses and Orthopedic Appliances.
- Intravenous medications and other Prescription Drugs ordinarily not available through a Retail Pharmacy.
- Nutritional counseling by a nutritionist or dietitian.
- Private duty nursing in the home.

Home infusion (IV) Therapy

Benefits for home infusion (IV) therapy include a combination of nursing, Durable Medical Equipment and pharmaceutical services in the home. Home IV therapy includes but is not limited to antibiotic therapy, hydration therapy and Chemotherapy. Intra-muscular, subcutaneous and continuous subcutaneous injections are also Covered Services.

Home Health Care Exclusions

The following services, supplies or care are not covered:

- Services or supplies for personal comfort or convenience including homemaker services.
- Food services, meals, formulas, and supplements other than listed above or resulting from dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Religious or spiritual counseling.

Hospice Care

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Summary of Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

Hospice Care is initially approved for a period of three months. Benefits may continue for up to two more three-month periods. Hospice benefits, if any, provided after the third three-month period will be determined in Our sole discretion. We reserve the right to review treatment plans. Covered Services include:

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care. Inpatient respite care may be limited to a maximum of five consecutive days per admission.
- Skilled nursing services, certified nurse aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Nutritional counseling by a nutritionist or dietitian.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of Your condition including oxygen and related respiratory therapy supplies.
- Transportation.
- Prosthesis and Orthopedic Appliances.

Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the Member's death. Bereavement services are available to surviving covered family members.

In order to receive Hospice benefits (1) Your Physician and the Hospice medical director must certify that You are terminally ill and generally have less than six months to live, and (2) Your Physician must consent to Your care by the Hospice and must be consulted in the development of Your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to Us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Booklet, are provided as set forth in other parts of this Booklet.

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most We will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that You use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.

- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

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

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when Your condition requires it.
- Benefits include treatment by two or more Physicians during one Hospital stay when the nature or severity of Your health problem calls for the skill of separate Physicians.
- A personal bedside exam by another Physician when asked for by Your Physician. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general Anesthesia.
- Newborn exam. A Physician other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.
- Private Duty Nursing.

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, limited to a maximum number of days per the Member's Benefit Period as listed on the Summary of Benefits.

Benefits include services in a Hospital, free-standing Facility or Skilled Nursing Facility. Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time.

Skilled Nursing Care Facility

When You require inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under State law as a Skilled Nursing Care Facility, or is otherwise licensed to provide the services, up to a maximum number of days per the Member's Benefit Period as listed on the Summary of Benefits. Custodial Care is not a Covered Service.

Surgery

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

- Accepted operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;

- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care.

Note: This section includes orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.

Mastectomy Notice

A Member who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

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

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this plan.

Reconstructive Surgery

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

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

Maternity Services and Newborn Care

Benefits are provided for maternity and newborn childcare, including diagnosis; care during pregnancy and for delivery services. Benefits are provided for:

- Inpatient, outpatient and Physician office services (including prenatal care) for vaginal delivery, cesarean section, and complications of pregnancy
- Anesthesia services.
- Routine nursery care for a covered newborn including Physician services.
- For covered newborns all Medically Necessary care and treatment of injury and sickness including medically diagnosed Congenital Defects and Birth Abnormalities.
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by Us.
- Circumcision of a covered newborn male.
- Laboratory services related to prenatal care or postnatal care.
- Spontaneous termination of pregnancy prior to full term.
- Abortions in the case of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed (i.e., abortions for which federal funding is allowed).
- Genetic testing when allowed by Our medical policy.

Under applicable law, We may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law as a rule does not stop the mother’s or newborn’s attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. If the baby is born between 8:00 p.m. and 8:00 a.m., coverage will continue until 8:00 a.m. on the morning after the 48 or 96 hour timeframe. In any case, as provided by federal law, We

may not require a Provider to get authorization from Us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

For information about enrolling a newborn child, see the DEPENDENTS heading in the ELIGIBILITY section.

Maternity and Newborn Care Exclusions

The following services, supplies or care are not covered:

- Non-urgent maternity care and/or deliveries outside the Service Area.
- Services including but not limited to preconception counseling, paternity testing, genetic counseling, or testing for inherited disorders, screening for disorders, discussion of family history or test results to determine the sex or physical characteristics of an unborn child.
- Storage costs for umbilical blood.

Medical Foods

Covered Services include Medically Necessary medical foods for home use for metabolic disorders which may be taken by mouth or enterally. A Provider must have prescribed the medical foods that are designed and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids. Such disorders include:

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

Covered Services do not include enteral nutrition therapy or medical foods for Members with cystic fibrosis or lactose- or soy- intolerance. Also all covered medical foods must be obtained through a Pharmacy and are subject to the pharmacy payment requirements. Please see “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” later in this section.

Mental Health and Substance Abuse Services

See the Summary of Benefits for any applicable Deductible, Co-insurance, Copayment, and Benefit Limitation information.

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that We must cover per State law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Outpatient Services** including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- **Residential Treatment** which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:
- Observation and assessment by a psychiatrist weekly or more often,
- Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

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

Office Visits and Doctor Services

Covered Services include:

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

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

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

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

Online Visits
When available in Your area, Your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

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

For a listing of In-Network Providers or Urgent Care Centers, please visit Our website at www.anthem.com

Prescription Drugs Administered in the Office

Outpatient Facility Services

Your Booklet includes Covered Services in an:

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

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

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

Prescription Drugs

What You Pay for Prescription Drugs

This section describes Covered Services and exclusions for outpatient Pharmacy, Prescription Drugs, and medications when obtained through a Retail Pharmacy, In-Network mail-order Pharmacy or Specialty Pharmacy.

Tier One, Tier Two, Tier Three, Tier Four

Your Deductible, Copayment and /or Co-insurance amounts may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to Your Summary of Benefits to determine Your Copayment, Co-insurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate 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 alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e. oral, injected, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Co-insurance will not be reduced by any discounts, rebates or other funds received by Our designated Pharmacy Benefits Manager (PBM) from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Us from Our designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If You have a question regarding whether a Drug is on the Prescription Drug Formulary, please contact the Customer Service telephone number on the back of your Identification Card.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e. oral, injected, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Booklet limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for Our other products. Benefits may not be covered for certain drugs if they are not on the Prescription Drug list. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Us. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Exception Request for a Drug not on the Prescription Drug List

If You, Your designee or Your doctor believe You need a Prescription Drug that is not on the Prescription Drug List, please have Your doctor or pharmacist get in touch with Us. We will cover the other Prescription Drug through a special exception process, but only if We agree that it is Medically Necessary and appropriate over the other Drugs that are on the list. We will make a coverage decision within 72 hours of receiving Your request, unless a shorter timeframe is required by applicable law. If We approve the coverage of the Drug, coverage of the Drug will be provided for the duration of Your prescription, including refills. If We deny coverage of the Drug, You have the right to to appeal, including the right to request independent external review, as explained in the Appeals section of this Booklet.

You, Your designee or Your Doctor may also submit a request for a Prescription Drug that is not on the Prescription Drug List based on exigent circumstances. Exigent circumstances exist if You are suffering from a health condition that may seriously jeopardize Your life, health, or ability to regain maximum function, or if You are undergoing a current course of treatment using a drug not covered by the plan. We will make a coverage decision within 24 hours of receiving Your request. If We approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. If We deny coverage of the Drug, You have the right to appeal, including the right to request independent external review, as explained in the Appeals section of this Booklet.

Coverage of a Drug approved as a result of Your request or Your Doctor's request for an exception will only be provided if You are a Member enrolled under the Booklet. For additional information about the exception processes for Drugs not included on Your plan's Prescription Drug List, please call the Customer Service telephone number on the back of Your Identification Card.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and You must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Legend Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-Administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the PREVENTIVE CARE SERVICES benefit. Please see that section for more details.
- Flu Shots (including administration).
- Drugs for sex change Surgery.

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

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

Where You Can Obtain Prescription Drugs

Your Booklet includes benefits for Prescription Drugs You get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail

Pharmacies, a Mail Service Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from Your Doctor and Your Identification Card and they will file Your claim for You. Refer to Your Summary of Benefits for any Copayment, Co-insurance, and/or Deductible that applies when You obtain Prescription Drugs. If You do not have Your Identification Card, the Pharmacy may charge You the full retail price of the Prescription and may not be able to file the claim for You. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies may be limited. If this happens, We may require You to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy for You.

Helpful tip: Benefits for Prescription Drugs, including Specialty Drugs, which must be administered to You in a medical setting (e.g., Doctor's office, home care visit, or outpatient Facility) are covered under the ADMINISTERED BY A MEDICAL PROVIDER benefit. Please read that section for important details.

Maintenance Medication - Home Delivery Complete

The PBM also has a Mail Service Pharmacy that You will use to obtain Drugs You take on a regular basis. If You are taking a Maintenance Medication, You may get the first 30 day supply plus one additional 30 day refill of the same Maintenance Medication at Your local Retail Pharmacy. You must then use the Mail Service Pharmacy.

You will need to contact the PBM to sign up when You first use the service. The first mail order Prescription You submit must include a completed patient profile form. This form will be sent to You upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You can mail written prescriptions from Your Doctor or have Your Doctor send the prescription to the Mail Service Pharmacy. The Prescription must state the dosage and Your name and address; it must be signed by Your Physician. You will need to send in any Copayments, Deductible, or Co-insurance amounts that apply when You ask for a prescription or refill. Refer to Your Summary of Benefits for any Copayment, Co-insurance, and/or Deductible, if any, that applies when You obtain Prescription Drugs.

Helpful Tip: We suggest that You order Your refill two weeks before You need it to avoid running out of Your medication. For any questions concerning the mail order program, You can contact the Customer Service telephone number on the back of your Identification Card.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program Customer Service department by calling the Customer Service telephone number on the back of your Identification Card for availability of the Drug or medication.

Specialty Pharmacy

Specialty Drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control.

Specialty Drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have Your Prescription for a Specialty Drug filled through the PBM's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver Your Specialty Drugs to You by mail or common carrier for self administration in Your home. You cannot pick up Your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or Your Physician may order Your Specialty Drug from the Specialty Preferred Program by contacting the Customer Service telephone number on the back of your Identification Card. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help You take charge of Your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer Your questions about Specialty Drugs. A Dedicated Care Coordinator will work with You and Your Doctor to get Preauthorization. When You call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide You through the process up to and including actual delivery of Your Specialty Drug to You. When You order Your Specialty Drug by telephone, You will need to use a credit or debit card to pay for it. You may also submit Your Specialty Drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once You have met Your Deductible, if any, You will only have to pay the cost of Your Copayment or Co-insurance as found in the Summary of Benefits. When You order Your Specialty Drug by mail, You will need to use a check, money order, credit or debit card to pay for it.

You or Your Physician may obtain a list of Specialty Drugs available through the Specialty Preferred Provider network by contacting the Customer Service telephone number on the back of your Identification Card or online at www.anthem.com. You or Your Physician may also obtain order forms by contacting Customer Service or by accessing Our website at www.anthem.com.

Urgent or Emergency need of a Specialty Drug subject to the Specialty Pharmacy Program

If You are out of a Specialty Drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow You to get a 72-hour Emergency supply of medication, or the smallest packaged quantity, whichever is greater, if Your Doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Co-insurance, if any.

If You order Your Specialty Drug through the Specialty Preferred Provider and it does not arrive, if Your Physician decides that it is Medically Necessary for You to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow You to get an Emergency supply of medication from a Participating Pharmacy near You. A Customer Service representative from the Specialty Preferred Provider will coordinate the exception and You will not be required to pay additional Co-insurance.

Important Details About Prescription Drug Coverage

Your Booklet includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, Your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age

limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Preauthorization, Step Therapy, and use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other Utilization Reviews. Your Participating Pharmacist will be told of any rules when You fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include Utilization Review of Prescription Drug usage for Your health and safety. Certain Drugs may require Preauthorization. Also, a Participating Pharmacist can help arrange Preauthorization or dispense an Emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify Your personal Physician and Your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Preauthorization

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

If Preauthorization is denied You have the right to file a Grievance as outlined in the APPEALS AND COMPLAINTS section of this Booklet.

For a list of Drugs that need Preauthorization, please call the phone number on the back of Your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under Your Booklet. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand or Generic Drugs are covered under Your Booklet.

Step Therapy

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

Administered by a Medical Provider

Your Booklet also covers Prescription Drugs when they are administered to You as part of a Doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and injectables that must be administered by a Provider. This section applies when Your Provider orders the Drug and administers it to You. Benefits for Drugs that You inject or get at a Pharmacy (i.e., Self-Administered Drugs) are not covered under this section. Benefits for those Drugs are described in the Benefit at a Retail or Home Delivery (Mail order) Pharmacy section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if Prescription Drugs are covered under the "Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the Summary of Benefits. In most cases, You must use a certain amount of Your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets You pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets You get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells You to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and You should talk to Your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of Your Identification Card.

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent and/or minimize wasted prescription drugs if Your Prescription Drugs or dose changes between fills, by allowing only a portion of Your prescription to be filled at a Specialty Pharmacy. This program also saves You out of pocket expenses.

The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. You can access the list of these prescription drugs by calling the toll-free Member services number on your Member ID card or log on to the Member website at www.anthem.com.

Special Programs

Except where prohibited by Federal Regulations (such as HSA rules), from time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Co-insurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Customer Service

For information and assistance, a Member may call or write Us. The telephone number for Customer Service is printed on the Member's Identification Card.

Our address is:

Anthem
Customer Service
P.O. Box 5747
Denver, CO 80217-5747

Monday through Friday - 7:30 a.m. to 6:30 p.m.

Preventive Care Services

Preventive care includes screenings and other services for adults and children with no current symptoms or history of a health problem.

Members who have current symptoms or a diagnosed health problem will get benefits under the "Diagnostic Services" benefit, not this benefit.

Preventive care services will meet the requirements of federal and State law. Many preventive care services are covered with no Deductible, Copayments or Co-insurance when You use an In-Network Provider. That means We cover 100% of the Maximum Allowed Amount. Covered Services fall under four broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:

a. Breast cancer.
b. Cervical cancer.
c. Colorectal cancer.
d. High blood pressure.
e. Type 2 Diabetes Mellitus.
f. Cholesterol.
g. Child and adult obesity.

2. Immunizations for children, adolescents, and adults, including cervical cancer vaccinations for females, where recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration; and
4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

    a. Women's contraceptives, sterilization treatments, and counseling. This includes Generic and single-source Brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered as Preventive Care benefits when Medically Necessary, otherwise they will be covered under the Prescription Drug benefit and subject to the Cost Sharing Prescription Drugs.
    b. Breastfeeding support, supplies, and counseling. Breast pumps must be received from an In-Network Provider. Benefits for breast pumps are limited to one per calendar Year or as required by law.
    c. Gestational diabetes screening.

The Food and Drug Administration (FDA) has approved 18 different methods of contraception. At least one product in all 18 approved methods of contraception is covered under this policy without cost sharing as required by federal and state law.

You may call Customer Service at the number on Your Identification Card for more details about these services or view the federal government's web sites:

- http://www.healthcare.gov/center/regulations/prevention.html
- http://www.ahrq.gov/clinic/uspstfix.htm,
- http://www.cdc.gov/vaccines/acip/index.html.

Your Booklet provides coverage for routine prostate cancer screenings for men to the extent required by law. Non-routine prostate exams are not part of the Preventive Care Services section and are subject to the provision of the Office Visits and Doctor Services section.

Sterilization Services

Benefits include sterilization services for men. Reversals of sterilizations are not covered. Sterilizations for women are covered under the Preventive Care Services benefit.

Telemedicine Services

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

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

Non-Covered Services are:

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

Therapy Services

Physical Medicine Therapy Services

Your plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve Your level of function within a reasonable period of time.

For children under age 6, Your plan covers at least 20 visits each of physical, speech and occupational therapy, for rehabilitation services. Your plan will also cover 20 visits each of physical, speech and occupational therapy, for habilitation services. Benefits include the treatment of Congenital Defects and Birth Abnormalities, even if it is a long term condition. It also doesn't matter if the reason for the therapy is to maintain (not improve) the child's skills.

Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.

Early Intervention Services

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

This visit limit does not apply to rehabilitation or therapeutic services that are necessary as the result of an acute medical condition or post-surgical rehabilitation, services provided to a child who is not participating in part C of the Individuals with Disabilities Education Improvement Act, or assistive technology that is covered by the policy's Durable Medical Equipment benefit provisions. The coverage for Early Intervention Services is in addition to any other coverage provided under this Booklet for Congenital Defects or Birth Abnormalities.

Habilitative Services

Benefits also include habilitative services that help You keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services

for people with disabilities in a variety of inpatient and/or outpatient settings. Please see the Summary of Benefits for the maximum visits per Member's Benefit Period.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation –** Medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents.
- **Dialysis –** Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore Your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transgender Surgery

This Booklet provides benefits for many of the charges for transgender Surgery (also known as sex reassignment Surgery). Benefits must be approved by Us for the type of transgender Surgery requested and must be authorized prior to being performed. **Charges for services that are not authorized for the transgender Surgery requested, will not be considered Covered Services. Some conditions apply, and all services must be authorized by Us.**

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

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

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, collection and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that We have chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to You and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

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

Unrelated Donor Searches

When approved by Us, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Contact the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility. Services received from an Out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Preauthorization and Precertification

In order to maximize Your benefits, You will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before You have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an In-Network Transplant Provider to receive maximum benefits. We will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, In-Network Transplant Provider requirements, or exclusions are applicable. Even if a Hospital is an In-Network Provider for other services, it may not be an In-Network Transplant Provider for certain transplant services. Please call us to find out which Hospitals are In-Network Transplant Providers. Contact the Customer Service telephone number on the back of Your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, You or Your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an In-Network Transplant Facility will maximize Your benefits.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage

request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

We will provide assistance with reasonable and necessary travel expenses as determined by Us when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. We will assist with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

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

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

- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation,
- Meals.

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

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine Your eligibility as a candidate for transplant by Your Provider and the mobilization, collection and storage of bone marrow / stem cells are included in the Covered Transplant Procedure benefit regardless of the date of service.

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member Cost Shares.

> **Helpful tip:** See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Vision Care For Pediatric Members

We cover the following vision care services for Members to the end of the month in which they turn age 19. We will cover vision care that is listed in this section when received from a Blue View Vision provider. Visit Our website or call the number on your ID card for help finding a Blue View Vision Provider. See

Your Summary of Benefits for the benefit frequencies and Your Cost Share amounts for covered vision care. We will not pay for vision care listed in the "Vision Care that is NOT Covered" section.

Routine Eye Exam

This Booklet covers a complete eye exam with dilation as needed. The exam is used to check all aspects of Your vision.

Eyeglass Lenses

You have a choice in Your eyeglass lenses. Lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic at no additional cost In-Network. If you choose lens options that are not listed as covered in the Summary of Benefits, you will have to pay all charges for those lens options. Covered eyeglass lenses include standard plastic (CR39) lenses up to 55 mm in:

- single vision
- bifocal
- trifocal (FT 25-28)

Frames

A selection of frames is available under this Booklet. Members must choose a frame from the plan's vision formulary.

Contact Lenses

The plan offers the following benefits for contact lenses:

- Elective Contact Lenses – Contacts chosen for comfort or appearance;
- Non-Elective Contact Lenses – Only for the following medical conditions:

    1) Keratoconus when Your vision is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
    2) High Ametropia exceeding -12D or +9D in spherical equivalent.
    3) Anisometropia of 3D or more.
    4) When Your vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

A selection of contact lenses is available under this Booklet. Members must choose contact lenses from the plan's vision formulary.

This plan only covers a choice of contact lenses or eyeglass lenses, but not both. If you choose contact lenses during the benefit period, no benefits will be available for eyeglass lenses until the next benefit period. If you choose eyeglass lenses during the benefit period, not benefit will be available for contact lenses until the next benefit period.

Vision Coverage Appeals

Please submit appeals regarding Your vision coverage to the following address:

Blue View Vision
555 Middle Creek Parkway
Colorado Springs, CO 80921

Dental Services – Dental Care for Pediatric Members

All Covered Services are subject to the terms, limitations, and exclusions of Your Booklet. See Your Summary of Benefits for Your Cost Share amounts, such as Deductibles and/or any Co-insurance.

Your Dental Benefits

We do not determine whether the dental services listed in this section are Medically Necessary to treat Your specific condition or restore Your dentition. There is a preset schedule of dental care services that are covered under this Booklet. We evaluate the procedures submitted to Us on Your claim to determine if they are a Covered Service under this Booklet.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are Cosmetic in nature, or exceed the benefit frequencies of this Booklet. While these services may be necessary for Your dental condition, they may not be covered by Us. There may be an alternative dental care service available to You that is covered under Your Booklet. These alternative services are called optional treatments. If an allowance for an optional treatment is available, You may apply this allowance to the initial dental care service prescribed by Your dentist. You are responsible for any costs that exceed the allowance, in addition to any Co-insurance or Deductible You may have.

The decision as to what dental care treatment is best for You is solely between You and Your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for You and Your dentist. It provides You and the dentist with an idea of what Your out of pocket costs will be for the dental care treatment. This will allow the dentist and You to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthodontic, endodontic, oral surgery, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for You to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on Your current eligibility and the Booklet benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in Your eligibility or changes to the Booklet may affect Our final payment.

You can ask Your dentist to submit a pretreatment estimate for You, or You can send it to Us Yourself. Please include the procedure codes for the services to be performed (Your dentist can tell You what procedures codes). Pretreatment estimate requests can be sent to the address on Your dental Identification Card.

Dental Providers

You do not have to select an In-Network dentist to receive dental benefits. You can choose any dentist You want for Your dental care. However, Your dentist choice can make a difference in what benefits are covered and how much You will pay out-of-pocket. You may have more out-of-pocket costs if You use a dentist that is an Out-of-Network dentist. There may be differences in the amount We pay between a In-Network dentist and an Out-of-Network dentist.

Please call the Customer Service phone number on the back of Your Identification Card for help in finding an In-Network dentist or visit Our website at www.anthem.com/mydentalvision. Please refer to your Identification Card for the name of the dental program that In-Network Providers have agreed to service when You are choosing an In-Network dentist.

Description of Covered Services

We cover the following dental care services for Members to the end of the month in which they turn age 19.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar Year.

- Comprehensive
- Periodic
- Limited
- Oral evaluation – under 3 years of age
- Detailed and extensive

Radiographs (X-rays)

- Full mouth x-rays (complete series) – Once per 60 months and includes bitewings
- Periapical(s)
- Bitewings – 1 series per 12-month period. Please note that this is not a benefit in addition to a full mouth x-ray.
- Panoramic film – Once per 60-month period.

Dental Cleaning (Prophylaxis) – Covered once per calendar Year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application) or fluoride varnish) Covered 2 times per 12-month period.

Sealants Covered only when given on permanent molar teeth with occlusal surfaces intact, no caries (decay) exists, and/ or there are no restorations. Coverage does not include prep or conditioning of tooth or any other procedure associated with sealant application. Repair or replacement of sealant on any tooth will not be covered within 36 months of application. Such repair or replacement given by the same dentist that applied the sealant is considered included in the allowance for initial placement of sealant.

Space Maintainers and Recementation of Space Maintainer - Covered only for premature loss of primary posterior (back) teeth.

Emergency (Palliative) Treatment (for pain relief)

Basic Restorative Services

Amalgam (silver) Restoration Treatment to restore decayed or fractured permanent or primary posterior (back) teeth. Covered once in a 24 month period per tooth surface.

Composite (white) Resin Restorations Covered once in a 24 month period for the same amalgam restoration.

- Anterior Teeth - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
- Posterior Teeth - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth. Coverage for a composite restoration on a posterior tooth is an optional treatment and will be equal to that of the amalgam restoration. You are responsible to pay for any difference between the Maximum Allowed Amount for an amalgam and the actual charge of the optional treatment.

Major Restorative Services

Recement Crown

Prefabricated Stainless Steel or Resin Crown - Covered once per tooth in a 24 month period.

Sedative Filling

Pin Retention – per tooth – in addition to restoration.

Oral Surgery

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth

Note: Surgical removal of 3rd molars are covered only if the removal is associated with symptoms of oral pathology.

Endodontic Services

Therapeutic Pulpotomy - Covered for primary teeth only

Root Canal Therapy - Covered for permanent teeth only

Orthodontic Care

Orthodontic Treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies, including treatment for conditions such as cleft lip and cleft palate. You should submit Your treatment plan to Us before You start any orthodontic treatment to make sure it is covered under this Booklet.

Dentally Necessary Orthodontic Care

To be considered Dentally Necessary Orthodontic Care, at least one of the following criteria must be present:

- There is spacing between adjacent teeth which interferes with the biting function;
- There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when You bite;
- Positioning of the jaws or teeth impair chewing or biting function;
- On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

Orthodontic treatment may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts/models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Complex Surgical Procedures – Surgical exposure of impacted or unerupted tooth for orthodontic reasons; or surgical repositioning of teeth.

Note: Treatment in progress (appliances placed prior to being covered under this Booklet will be covered on a pro-rated basis.

Orthodontic Exclusions

Coverage is NOT provided for:

- Monthly treatment visits that are inclusive of treatment cost;

- Repair or replacement of lost/broken/stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- Inpatient or outpatient Hospital expenses (please refer to Your medical coverage to determine if this is a covered medical service); and
- Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, payments are made over the course of Your treatment. You must have continuous coverage under this plan in order to receive ongoing payments for Your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this coverage ends.

Before treatment begins, the treating dentist should submit a pre-treatment estimate to Us. An Estimate of Benefits form will be sent to You and Your dentist indicating the estimated Maximum Allowed Amount, including any amount (Deductible or Coinsurance) You may owe. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of appliance placement and his/her signature. After benefit and eligibility verification by Us, a payment will be issued. A new/revised Estimate of Benefits form will also be issued to You and Your dentist. This again will serve as the claim form to be submitted 6 months from the date of appliance placement.

Dental Appeals

Please submit appeals regarding Your dental coverage to the following address:

Anthem
PO Box 1122
Minneapolis, MN 55440-1122

SECTION 8. LIMITATIONS/EXCLUSIONS (What is Not Covered)

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

Abortion: For abortions for which Federal funding is not allowed in accordance with Affordable Care Act section 1303(b)(1)(B)(i), namely all abortions except in the case of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed.

Acupuncture/Nerve Pathway therapy: Services or supplies related to the use of needles inserted along specific nerve pathways, regardless of the type of Provider performing the service.

Affiliated Providers: Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

After Hours or Holidays Charges: Additional charges beyond the Maximum Allowable Amount for basic and primary services requested after normal Provider service hours or on holidays.

Allergy Tests/Treatment: The following allergy tests and treatment:

- IgE RAST tests unless intradermal tests are contraindicated.
- Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
- Food allergy test panels (including SAGE food allergy panels).
- Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

Alternative/Complementary Medicine: For (services or supplies related to) alternative or complementary medicine, regardless of the Provider rendering such services or supplies. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bio energetic synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

Ambulance: Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any Ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non-Covered Services for Ambulance include but are not limited to, trips to:

- A Physician's office or clinic.
- A morgue or funeral home.

Coverage is not available for air Ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific Hospital or Physician. Air Ambulance services are not covered for transport to a Hospital that is not an Acute Care Hospital, such as a nursing facility, Physician's office, or Your home.

Armed Forces/War: For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

Artificial/Mechanical Devices - Heart Condition: Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

Bariatric Surgery: For bariatric Surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass Surgery or other gastric bypass Surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric Surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric Surgery, as determined by Us, are not covered. This exclusion applies when the bariatric Surgery was not a Covered Service under this plan or any previous one of Our plans and it applies if the Surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Booklet. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

Breast Reduction/Augmentation: Removal or replacement of a breast implant that was initially done for augmentation or for Cosmetic purposes Reduction or augmentation mammoplasty is excluded unless associated with breast Reconstruction Surgery following a Medically Necessary mastectomy resulting from cancer. No coverage is provided for surgical treatment of gynecomastia.

Charges After Termination Date: Charges incurred after the termination date of this coverage.

Charges Before Effective Date: Incurred prior to Your Effective Date.

Cochlear Implants: For cochlear implants. Except as specified in the BENEFITS/COVERAGE (WHAT IS COVERED) section of this Booklet.

Complications of Non-Covered Services: Care for problems directly related to a service that is not covered by this Booklet. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

Corrective Eye Surgery: For eye Surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

Cosmetic Services: Provided in connection with Cosmetic services. Cosmetic services are primarily intended to preserve, change or improve Your appearance or are furnished for psychiatric, psychological or social 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). Complications directly related to Cosmetic services, treatment or Surgery, as determined by Us, are not covered. This exclusion applies even if the original Cosmetic services treatment or Surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Booklet. Directly related means that the treatment or Surgery occurred as a direct result of the Cosmetic services treatment or Surgery and would not have taken place in the absence of the Cosmetic services treatment or Surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or Reconstructive Surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift Surgery on the unaffected breast to produce a symmetrical appearance. This exclusion does not apply to Reconstructive Surgery.

Counseling Services: Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy

Court Ordered Care: for court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

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

Custodial Care, Services/Care Other Facilities: We do not pay services, supplies, for the following:

- Custodial Care, convalescent care or rest cures. This exclusion does not apply to hospice care.
- Domiciliary care, regardless of the Provider rendering such care.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, or outward bound programs, even if psychotherapy is included.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

Dental Care

Coverage is NOT provided for:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Booklet.
- New, Experimental or Investigational dental techniques or services may be denied until there is, to Our satisfaction, an established scientific basis for recommendation.
- Dental services completed prior to the date the Member became eligible for coverage.
- Services of anesthesiologists.
- Analgesia, analgesia agents, anxiolysis, nitrous oxide, medicines, or drugs for non-surgical or dental care
- Intravenous conscious sedation, IV sedation and general Anesthesia are not covered when given with non-surgical dental care. EXCEPTION: General Anesthesia for dental services for Members under age 19 years of age when rendered in a Hospital, outpatient surgical facility or other facility licensed pursuant to Section 25-3-101 of the Colorado Revised Statutes if the child, in the opinion of the treating Dentist, satisfies one or more of the following criteria: (a) the child has a physical, mental, or medically compromising condition; (b) the child has dental needs for which local Anesthesia is ineffective because of acute infection, anatomic variations, or allergy; (c) the child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or (d) the child has sustained extensive orofacial and dental trauma.
- Dental services performed other than by a licensed dentist, licensed Physician, his or her employees, or a licensed provider acting within the scope of the provider's license.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Services or supplies that have the primary purpose of improving the appearance of Your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Restorations placed for preventative or Cosmetic purposes.

- Occlusal or athletic mouth guards.
- Prosthodontic services, such as dentures or bridges.
- Periodontal services, such as scaling and root planing.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Booklet.
- Separate services billed when they are an inherent component of another covered service.
- Temporomandibular Joint Disorder (TMJ) except as covered under Your medical coverage.
- Oral hygiene instructions.
- Surgical exposure of impacted or unerupted teeth for orthodontic reasons, except as listed in this Booklet.
- Surgical repositioning of teeth, except as listed in this Booklet.
- Case presentations, office visits and consultations.
- Implant services.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
- Services or supplies that are medical in nature, including dental oral Surgery services performed in a Hospital, except as covered under Your medical coverage.
- Adjunctive diagnostic tests.

Education/Training: For services or supplies primarily for educational, vocational, or training purposes, except as specified in the BENEFITS/COVERAGE (WHAT IS COVERED) section of the Booklet.

Exams - Research Screenings: For examinations relating to research screenings.

Experimental or Investigative: Which are Experimental or Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental or Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental or Investigative.

Eyeglasses/Contact Lenses: For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular Surgery, or for soft contact lenses due to a medical condition.

Family/Self: Services prescribed, ordered or referred by, or received from a Member of Your immediate family, including Your Spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

Feet - Surgical Treatment: For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.

Foot Care – Routine: For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:

- cleaning and soaking the feet.
- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

Forms/Medical Records: For completion of claim forms or charges for medical records or reports unless otherwise required by law.

Government Coverage: To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

Hearing Aids: For hearing aids or examinations for prescribing or fitting them, except as specified in the BENEFITS/COVERAGE (WHAT IS COVERED) section of this Booklet.

Hospice Care Exclusions: The following services, supplies or care are not covered:

- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the Member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

Human Growth Hormone: Human Growth Hormone

Hyperhydrosis: For treatment of hyperhidrosis (excessive sweating).

Impotency: Services and supplies related to male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing, except as authorized by Us in connection with Transgender Surgery noted in this Booklet.

Incarceration: For care required while incarcerated in a federal, State or local penal institution or required while in custody of federal, State or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

Infertility Testing and Treatment: For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis.

Maintenance Therapy: For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

Manipulation Therapy: Except as specifically stated as covered under the Home Care Services benefit of this booklet, all services related to Manipulation Therapy are not covered, regardless of the type of provider rendering the service. This includes manual manipulation of the spine, X-ray of the spine in connection with Manipulation Therapy, and certain physical modalities and procedures associated with Manipulation Therapy.

Maximum Allowable Amount: In excess of Our Maximum Allowable Amounts.

Missed/Cancelled Appointments: For missed or canceled appointments.

New FDA Approved Drug Product or Technology for First 6 Months After Approval: 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. The plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

No legal obligation to pay: For which You have no legal obligation to pay in the absence of this or like coverage.

Non Authorized Travel Related Expenses: For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

Non Emergency Care Received in Emergency Room: For care received in an Emergency room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency room.

Non-Medically Necessary Services: Which We determine is not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

Nutritional and Dietary Supplements: For nutritional and dietary supplements, except as provided in the BENEFITS/COVERAGE (WHAT IS COVERED) section of this 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 the written prescription or dispensing by a licensed pharmacist.

Over the Counter: For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this contract or as required by law.

Personal Hygiene, Environmental Control or Convenience Items: For personal hygiene, environmental control, or convenience items including but not limited to:

1. Air conditioners, humidifiers, air purifiers;
2. Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; 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 or similar facility.
3. Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
4. Charges from a health spa or similar facility;
5. Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
6. Charges for non-medical self-care except as otherwise stated;
7. Purchase or rental of supplies for common household use, such as water purifiers;
8. Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
9. Infant helmets to treat positional plagiocephaly;
10. Safety helmets for Members with neuromuscular diseases; or
11. Sports helmets.

Physical exams and immunizations - other purposes: Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

Physical Fitness: For 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.

Physician Stand-by Charges: For stand-by charges of a Physician.

Physician/Other Practitioners' Charges:

1. Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
2. Surcharges for furnishing and/or receiving medical records and reports.
3. Charges for doing research with Providers not directly responsible for Your care.
4. Charges that are not documented in Provider records.
5. Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, Orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.

6. For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

Prescription Drugs:

Your Prescription Drug benefits do not cover:

1. Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manger PBM.
2. Clinically-Equivalent Alternatives Certain Prescription Drugs are no longer covered when Clinically Equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Us to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to Us, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the Clinically Equivalent alternative.
3. Compound Drugs.
4. Contrary to Approved Medical and Professional Standards Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.
5. Delivery Charges: Charges for delivery of Prescription Drugs.
6. Drugs Given at the Provider's Office / Facility Drugs You take at the time and place where You are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
7. Drugs that do not need a prescription by federal law (including Drugs that need a prescription by State law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that we must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
8. Drugs Over Quantity or Age Limits Drugs in quantities which are over the limits set by Us, or which are over any age limits set by Us.
9. Drugs over the Quantity Prescribed or Refills after One Year Drugs in amounts over the quantity prescribed, or for any refill given more than one Year after the date of the original Prescription Order.
10. Items Covered as Durable Medical Equipment (DME) Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
11. Over the counter Drugs, devices or products, are not Covered Services.
12. An allergenic extract or vaccine.
13. Lost or Stolen Drugs Refills of lost or stolen Drugs.
14. Mail Service Programs other than the PBM's Home Delivery Mail Service Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
15. Non-approved Drugs: Drugs not approved by the FDA.
16. Off label use, unless We must cover the use by law or if We, or the PBM, approve it.
17. Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
18. Over-the-Counter Items Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
19. Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
20. Syringes Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
21. Weight Loss Drugs Any Drug mainly used for weight loss.
22. Drugs used for Cosmetic purposes.
23. Prescription Drugs used to treat infertility.

Private Duty Nursing: For Private Duty Nursing Services unless specifically stated in the BENEFITS/COVERAGE (WHAT IS COVERED) section.

Provider Services: Provider Services You get from Providers that are not licensed by law to provide Covered Services, as defined in this Booklet. Examples of such Providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

Provider Type: Received from an individual or entity that is not a Provider, as defined in this Booklet, or recognized by Us.

Providers located outside the United States: Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and Emergency Ambulance.

Reconstructive Services: Reconstructive services except as specifically stated in the BENEFITS/COVERAGE (WHAT IS COVERED) section, or as required by law.

Regression Prevention: For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

Reversal of Sterilization: For reversal of sterilization.

Riot, Nuclear Explosion: For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

Self-Help Training/Care: For self-help training and other forms of non-medical self care, except as otherwise provided herein.

Shock Wave Treatment: Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

Spinal Decompression Devices: For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

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

Teeth - Congenital Anomaly: Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Booklet or as required by law.

Teeth, Jawbone, Gums: For treatment of the teeth, jawbone or gums that are required as a result of a medical condition except as expressly required by law or specifically stated in this Booklet as a Covered Service.

Telephone/Internet Consultations: For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated in the BENEFITS/COVERAGE (WHAT IS COVERED) section of this Booklet.

Therapy – Other: Services, supplies, and equipment for the following:

1. Gastric electrical stimulation.
2. Hippotherapy.
3. Intestinal rehabilitation therapy.
4. Prolotherapy.
5. Recreational therapy.
6. Sensory integration therapy (SIT).

Vein Treatment: Treatment of varicose veins or telanqiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for Cosmetic purposes.

Vision Care that is NOT Covered:

We will not pay for services incurred for, or in connection with, any of the items below. Your Vision care services do not include:

1. Vision care for Members age 19 and older.
2. Contact lenses.
3. For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
4. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
5. For which the Member has no legal obligation to pay in the absence of this or like coverage.
6. Prescribed, ordered or referred by, or received from a Member of the Member's immediate family, including the Member's Spouse, child, brother, sister or parent.
7. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
8. For missed or canceled appointments.
9. For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Booklet or as otherwise prohibited by federal law.
10. For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
11. Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a network Provider).
12. For inpatient or outpatient Hospital vision care, unless covered by the medical benefits of this Booklet.
13. For orthoptics or vision training and any associated supplemental testing.
14. For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Booklet.
15. For services or supplies not specifically listed in this Booklet.
16. For vision care received Out-of-Network.
17. For safety glasses and accompanying frames.
18. For two pairs of glasses in lieu of bifocals.
19. For plano lenses (lenses that have no refractive power).
20. Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
21. Cosmetic lenses or options.
22. Blended lenses.
23. Oversize lenses.
24. Certain limitations on low vision.
25. Optional Cosmetic processes.
26. For sunglasses.
27. For services or supplies combined with any other offer, coupon or in-store advertisement.

Vision Orthoptic Training: For vision orthoptic training.

Waived Copayment, Co-insurance, or Deductible: For any service for which You are responsible under the terms of this Contract to pay a Copayment, Co-insurance, or Deductible and the Copayment, Co-insurance or Deductible is waived by a Out-of-Network Provider.

Weight Loss Programs: For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Booklet. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Workers Compensation: For any condition, disease, defect, ailment, or injury arising out of and in the course of employment, except as specifically covered in this Booklet.

SECTION 9. MEMBER PAYMENT RESPONSIBILITY

Cost Sharing Requirements

Your plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that You must pay when receiving Covered Services. Your plan may also have an Out-of-Pocket Limit, which limits the cost-shares You must pay. Please read the "Summary of Benefits (Who Pays What)" for details on Your cost-shares. Also read the "Definitions" section for a better understanding of each type of Cost Share.

Maximum Allowed (Allowable) Amount (MAA)

General

Reimbursement for services rendered by Network/participating and Out-of-Network Providers is based on the plan's Maximum Allowed Amount for the Covered Service that You receive. Please see the "Inter-plan Arrangements" section of this Contract for additional information.

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

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in Your Contract.

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

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

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

Provider Network Status

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

A Network Provider or participating Provider is a Provider who is in the managed network for this specific plan or in a special Center of Excellence/or other closely managed specialty network. For Covered Services performed by a Network Provider or participating Provider, the Maximum Allowed Amount for this plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Network Providers and participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Network Provider or participating Provider, or visit www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Out-of-Network Providers, subject to Blue Cross and Blue Shield Association rules governing claims filed by certain ancillary Providers.

For Covered Services You receive from a Out-of-Network Provider that have been Prior Authorized by Us, the Maximum Allowed Amount for this plan will be one of the following as determined by Anthem:

1) An amount based on Our non-participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers’ fees and costs to deliver care; or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through Case Management; or
5) An amount based on or derived from the total charges billed by the Out-of-Network Provider.

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

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

Customer Service is also available to assist You in determining this plan’s Maximum Allowed Amount for a particular service from a Out-of-Network Provider. In order for Us to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider’s charges to calculate Your out of pocket responsibility. Although Customer Service can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using Prescription Drug cost information provided by the Pharmacy Benefits Manager (PBM).

Member Cost-Share

For certain Covered Services and depending on Your plan design, You may be required to pay a part of the Maximum Allowed Amount as Your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

What Does Not Count Toward the Out-of-Pocket Limit

Not all amounts that You pay toward Your health care costs are counted toward Your Out-of-Pocket Limit. Some items never count toward the Out-of-Pocket Limit, and once Your Out-of-Pocket Annual Maximum has been met, they are never paid at 100%. These items include:

- amounts over the Maximum Allowed Amount;
- amounts over any policy maximum or limitation;
- expenses for services not covered under this Contract; and
- any other amounts that are identified as excluded on the Summary of Benefits.

Authorized Services

In some non-Emergency circumstances, such as where there is no In-Network Provider available for the Covered Service, We may Preauthorize the network Cost-Share amounts (Deductible, Copayment, and/or Co-insurance) to apply to a claim for a Covered Service You receive from a Out-of-Network Provider. In such circumstance, You must contact Us in advance of obtaining the Covered Service. We also will authorize the In-Network Cost-Share amounts to apply to a claim for Covered Services if You receive Emergency Services from an Out-of-Network Provider and are not able to contact Us until after the Covered Service is rendered. If We authorize a Network Cost Share amount to apply to a a Covered Service received from an Out-of-Network Provider, You may also still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Customer Service for Preauthorized services information or to request authorization.

Copayment

Copayments may be required for Covered Services. A Copayment is a set, fixed-dollar amount You must pay to receive a specific service. You are required to pay Your Copayments to Providers for specific Covered Service as listed in the Summary of Benefits. You need to pay Copayments directly to the Provider. You must pay Your Copayment even after meeting Deductible and/or Co-insurance requirements. Copayment amounts do not apply to the Deductible. Copayment amounts are listed in the Summary of Benefits.

Co-insurance

Co-insurance means the percentage of the Maximum Allowed Amount that is Your share of the cost for a Covered Service. For example, if Your Co-insurance percentage is 20% of the Maximum Allowed Amount, You are responsible for 20% of the Maximum Allowed Amount. See the explanation of Maximum Allowed Amount in this section for information on negotiated payment arrangements. Co-insurance is required for Covered Services until the Out-of-Pocket Annual Maximum is reached for each Benefit Period. Once the Out-of-Pocket Annual Maximum is reached, We pay 100% of any remaining eligible Billed Charges for the remainder of the Benefit Period.

Deductible

A Deductible is a specified dollar amount for Covered Services that the Member must pay within each calendar Year before Anthem reimburses for covered benefits. A Copayment may be required before the Deductible for certain Covered Services. The Deductible amount is listed in the Summary of Benefits. A new Deductible is required for each Benefit Period.

Deductible Calculation

Each family Member's Maximum Allowed Amount for Covered Services is applied to his/her individual Deductible. Once two or more family Members' Maximum Allowed Amount for Covered Services combine

to equal the family Deductible, then no other Individual Deductible needs to be met for that calendar Year. No one person can contribute more than his/her Individual Deductible to the Family Deductible.

The In-Network and Out-of-Network Deductibles are separate and do not apply toward each other.

The Deductible applies to most Covered Services even those with a zero percent Co-insurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how Your plan works, please refer to the Summary of Benefits.

The Deductible and Copayment/Co-insurance amount incurred in a calendar Year apply to the Out-of-Pocket Annual Maximum.

Out-of-Pocket Annual Maximum

The Out of Pocket Annual Maximum for Covered Services is the sum of the Deductible and Copayment/Co-insurance maximums paid in a Benefit Period. “Out-of-Pocket Annual Maximum” is the most You pay for Covered Services in a Benefit Period. Once You meet Your Deductible and Out-of-Pocket Annual Maximum Your Booklet will cover 100% of the Maximum Allowed Amount for Covered Services for the rest of that Benefit Period.

Out-of-Pocket Annual Maximum Calculation

The Deductible, Co-insurance,* and Copayment amounts incurred in a calendar Year apply to the Out-of-Pocket Annual Maximum.

The individual Out-of-Pocket Annual Maximum applies to each covered family Member. Once two or more covered family Members’ Out-of-Pocket Annual Maximum combine to equal the family Out-of-Pocket Annual Maximum amount, the Out-of-Pocket Annual Maximum will be satisfied for the family for that calendar Year. No one person can contribute more than their individual Out-of-Pocket Annual Maximum.

Once the In-Network Out-of-Pocket Annual Maximum is satisfied, no additional In-Network Cost Sharing will be required for the remainder of the calendar Year.

Once the Out-of-Network Out-of-Pocket Annual Maximum is satisfied, no additional Out-of-Network Cost Sharing will be required for the remainder of the calendar Year, except for Out-of-Network Human Organ and Tissue Transplant services.

In-Network and Out-of-Network Co-insurance and Out-of-Pocket Annual Maximum are separate and do not accumulate toward each other.

*The Out-of-Network Out-of Pocket Annual Maximum does not include Co-insurance for any Out-of-Network Human Organ Tissue Transplant.

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

Benefit Period Maximum

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

If, within the same Year, you replace any Anthem individual medical plan with another Anthem individual medical plan, any benefits applied toward the Deductible or In-Network or Out-of-Network Provider Out-

of-Pocket Annual Maximum, will be applied toward the Deductible and In-Network or Out-of-Network Provider Out-of-Pocket Annual Maximum.

Also, if You leave this plan, and go on to a new plan with Us in the same Year, all covered benefits that have a Benefit Period Maximum may be carried over to the new plan. For instance, if a benefit has a limit of one visit per Benefit Period and You received that benefit under the prior coverage, then You are not eligible under the new plan for the same benefit until the Benefit Period ends, as benefits have been exhausted for Your Benefit Period.

SECTION 10. CLAIMS PROCEDURE (How to File a Claim)

This section describes how We reimburse claims and what information is needed when You submit a claim. When You receive care from an In-Network Provider, You do not need to file a claim because the In-Network Provider will do this for You. If You receive care from an Out-of-Network Provider, You will need to make sure a claim is filed. Many Out-of-Network Hospitals, Doctors and other Providers will file Your claim for You, although they are not required to do so. If You file the claim, use a claim form as described later in this section.

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

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

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

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

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

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

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

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

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

Anthem Claims
P.O. Box 5747

Denver, CO 80217-5747

If You die, any claims payable to You will be paid to Your beneficiary or Your estate. If the Provider is an In-Network Provider, claim payments will be made to the Provider.

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

Inter-Plan Arrangements

Out-of-area services

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. These are referred to generally as "Inter-Plan Programs." When You obtain Covered Services outside of Our Service Area, the claims may be processed through one of these Inter-Plan Programs. These programs include the BlueCard Program, described below. They may also include negotiated national account arrangements between Us and other Blue Cross and Blue Shield Licensees.

Typically, when You access medical care outside Our Service Area, You will obtain it from Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other area ("Host Blue"). But in some cases, You may obtain care from Out-of-Network Providers. Our payment practices in both cases are generally described below.

BlueCard® Program

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

When You obtain Covered Services outside Our Service Area and the claim is processed through the BlueCard Program, the amount You pay is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Us.

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

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

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any State law mandates other liability calculation methods, including a surcharge, We calculate a member's liability for any covered service according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When You obtain Covered Services from Out-of-Network healthcare Providers outside of Our Service Area, the amount You pay for the services and supplies will generally be based on either: (a) the Host Blue's Out-of-Network Provider local payment; or (b) the pricing arrangements required by applicable State law. In these cases, You may be responsible for the difference between: (a) the amount that the Out-of-Network Provider bills; and (b) the payment We make for the Covered Services.

In some cases, We may pay such claims differently than described above. For example, Our payment for Covered Services obtained from Out-of-Network Providers could be made based on: (a) billed Covered Charges; (b) the payment We would make if the Covered Services had been obtained within its Service Area; or (c) a special negotiated payment, as allowed under Inter-Plan Program rules. In these cases, You may be liable for the difference between: (a) the amount that the Out-of-Network healthcare Provider bills; and (b) the payment We make for the Covered Services.

Travel outside the United States – BlueCard Worldwide

If You plan to travel outside the United States, call customer service to find out about Your plan benefits. Benefits for services received outside of the United States are different from services received in the United States and only include Emergency Care, Urgent Care and Emergency Ambulance services. Remember to take an up to date health ID card with You.

When You are traveling abroad and need medical care

You can call the BlueCard Worldwide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or You can call them collect at 804-673-1177. An Assistance Coordinator will speak with You and help to set up an appointment with a Doctor or Hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for You.

If You need inpatient Hospital care, You or someone on Your behalf, should contact Us for Prior Authorization. Keep in mind, if You need Emergency medical care, go to the nearest Hospital. There is no need to call before You receive care.

Please refer to the “Requesting Approval for Benefits” section. You can learn how to get Prior Authorization when You need to be admitted to the Hospital for Emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when You arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating Hospital, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

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

- Doctors services;
- Inpatient Hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

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

When You need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

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

SECTION 11. GENERAL POLICY PROVISIONS

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

Change of Beneficiary: Upon the death of a Member, claims will be payable in accordance with the beneficiary designation. If no such designation is in effect, claims payments will be payable to the Member's estate. If the Provider is a participating Provider, claims payments will be made to the Provider.

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

Conformity with State Statutes: Any provision of this Booklet which, on its Effective Date, is in conflict with the statutes of the State in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

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

Entire Contract Changes: This Booklet including the endorsements and attached papers if any constitutes the entire contract of insurance. No change in this Booklet shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this Booklet or to waive any of its provision.

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

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

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

If fraud is suspected, You should contact Our Customer Service.

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

Insurance With Other Insurers. Expense Incurred Benefits: If there is other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this Booklet shall be for such proportion of the indemnities otherwise

provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this Booklet) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the Premium paid as shall exceed the pro rata portion for the indemnities thus determined.

Insurance With Other Insurers. Other Benefits: If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this Booklet shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of like amounts under all such other valid coverage's for the same loss of which this insurer had notice bears to the total like amounts under all valid coverage's for such loss, and for the return of such portion of the Premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the 'like amount' of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

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

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

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

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

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

Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this Booklet shall be such as the Premium paid would have been if purchased at the correct age.

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

Notice of Claim: Written notice of injury on which claim is based must be given to Us within 365 days after the date of the accident causing such injury. Such notice given by or on behalf of the Subscriber to Us at its home office or to any authorized agent of Ours, with particulars sufficient to identify the Subscriber, shall be deemed to be notice to Us. Failure to give notice within the time provided herein shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as reasonably possible.

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

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

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

Other insurance in this insurer: Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, the insured's beneficiary, or the estate of the insured, as the case may be, and the insurer will return all Premiums paid for all other such policies.

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

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

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

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

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

Proofs of loss: Written proof of loss must be furnished to Us at Our home office within 365 days after the date of the loss for which claim is made. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time

Relationship of Parties (Anthem and In-Network Providers): The relationship between Us and In-Network Providers is an independent contractor relationship. In-Network Providers are not agents or employees of Ours, nor Anthem, or any employee of Anthem, an employee or agent of In-Network Providers.

Your health care Provider is solely responsible for all decisions regarding Your care and treatment, regardless of whether such care and treatment is a Covered Service under this plan. We 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 You while receiving care from any In-Network Provider or for any injuries suffered by You while receiving care from any In-Network Provider's Facilities.

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

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

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

Sending Notices: All Subscriber notices are considered sent to and received by the Subscriber when deposited in the United States mail with postage prepaid, or where permitted by law sent electronically, and addressed to the Subscriber at the latest address in Our membership records.

Time limit on certain defenses: After two Years from the date of issue of this Booklet, no misstatements, except fraudulent misstatements, made by the Subscriber in the application for such policy will be used to void the policy or to deny a claim for loss incurred or disability (as defined in the Booklet) commencing after the expiration of such two-Year period.

The foregoing the Plan provision shall not be so construed to affect any legal requirement for avoidance of the Plan or denial of a claim during such initial two-Year period, nor to limit the application of information in this provision in the event of misstatement with respect to age or occupation or other insurance.

After this Plan has been in force for a period of two Years during the lifetime of the Subscriber (excluding any period during which the Subscriber is disabled), it shall become incontestable as to the statements contained in the Enrollment Application or Change of Coverage Application.

Medicare-Eligible Members

The Subscriber and Dependents who are non-Medicare eligible and who reside in Colorado are eligible to enroll for coverage. A Member who is under age 65 at the time of enrollment but who later becomes eligible for Medicare Part A, B, C and/or Part D, is eligible to continue coverage with this coverage as secondary to any Medicare benefits. Medicare will be the primary carrier for such Members.

Workers' Compensation

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

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

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

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

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

Automobile Insurance Provisions

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

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

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

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

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

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

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

Third Party Liability: Subrogation and Right of Reimbursement

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

Subrogation

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

- If You have been fully compensated, We have a lien against all or a portion of the benefits that have been paid to You from the following parties, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, Your own insurer (for example, uninsured, underinsured, medical payments or no-fault coverage, or a worker's compensation insurer), or any other person, entity, policy or Plan that may be liable or legally responsible in relation to the injuries or illness. However, Our Recovery cannot exceed the amount actually paid by Us under Your Booklet as it relates to the injuries or illness that are the subject of the subrogation action; and
- You and Your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them. If You have not pursued a claim against a third party allegedly at fault for Your injuries by the date that is sixty (60) days

before to the date on which the applicable statute of limitations expires, We have a right to bring legal action against the at-fault party.

Right of Reimbursement

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

- You must reimburse Us to the extent of the health insurance benefits We paid on the Member's behalf from any Recovery, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, Your own insurer (for example, underinsured, medical payments, or a worker's compensation insurer), or any other person, entity, policy or Plan that may be liable or legally responsible in relation to the injuries or illness;
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of reimbursement; and
- You, a person who represents Your legal interest or beneficiary must hold in trust for Us right away the amount recovered in gross that is to be paid to Us. The amount recovered in gross is the total amount of Your Recovery reduced by Your lawyer fees and costs.

The Member's Duties

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

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist You in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that You have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage You to get certain care when You need it and are separate from Covered Services under Your Plan. These programs are not guaranteed and could be discontinued at any time. We will give You the choice and if You choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, You may receive incentives such as gift cards or retailer coupons, which we encourage You to use for health and wellness related activities or items. Under other clinical quality programs, You may receive a home test kit that allows You to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any Cost Shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. (If You have any questions about whether receipt of a gift card or retailer coupon results in taxable income to You, we recommend that You consult Your tax advisor.)

Medicare-Eligible Members

The Subscriber and Dependents who are non-Medicare eligible and who reside in Colorado are eligible to enroll for coverage. A Member who is under age 65 at the time of enrollment but who later becomes eligible for Medicare Part A, B, C and/or Part D, is eligible to continue coverage with this coverage as secondary to any Medicare benefits. Medicare will be the primary carrier for such Members.

Network Access Plan

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

Not Liable for Provider Acts or Omissions

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

Policies and Procedures

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

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

Relationship of Parties (Us and In-Network Providers)

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

Your health care Provider is solely responsible for all decisions regarding Your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We 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 You while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

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

Unauthorized Use of Identification Card

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

Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which You may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, You may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the plan but are in addition to plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under Your Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

SECTION 12. TERMINATION/NONRENEWAL/ CONTINUATION

Termination

This section describes how coverage for a Member can be terminated, cancelled, rescinded, suspended or not renewed.

Termination of the Member

Unless prohibited by law, the Member's coverage will terminate if any of the following occurs:

1) The Member terminates his/her coverage with appropriate notice to Us.
2) The Member no longer meets the eligibility requirements for coverage under this Booklet.
3) The Member fails to pay his or her Premium, and the grace period has been exhausted.
4) Rescission of the Member's coverage.

Effective Dates of Termination

Except as otherwise provided, Your coverage may terminate in the following situations. This information provided below is general, and the actual Effective Date of termination may vary based on Your specific circumstances; for example, in no event will coverage be provided beyond the date Premium has been paid in full:

- If You terminate Your coverage, termination will be effective on the last day of the billing period in which We receive Your notice of termination.
- If the Member moves outside of the Service Area, or the Member is not located within the Service Area, coverage terminates for the Member and all covered Dependents at the end of the billing period that contains the date the Member failed to meet any of the conditions above regarding the Service Area.
- A Dependent's coverage will terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent. The coverage of a partner to a civil union, or the child of a partner to a civil union, ends at the end of the month of the date of dissolution or termination of the civil union.
- If You permit the use of Your or any other Member's Identification Card by any other person; use another person's card; or use an invalid card to obtain services, Your coverage will terminate immediately upon Our written notice. Any Subscriber or Dependent involved in the misuse of an Identification Card will be liable to and must reimburse Us for the Maximum Allowed Amount for services received through such misuse.
- If You engage in fraudulent conduct furnish Us fraudulent or misleading material information relating to claims, or if You knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Booklet, then We may terminate Your coverage. Termination is effective 31 days after Our notice of termination is mailed. We will also terminate Your Dependent's coverage, effective on the date Your coverage is terminated.
- If You stop being an eligible Subscriber, or do not pay the required Premium, coverage terminates for all Members at the end of the period for which payment was made subject to the Grace Period.

IMPORTANT: Termination of the Booklet automatically terminates all Member coverage as of the date of Termination, whether or not a specific condition was incurred prior to the Termination date. Covered Services are eligible for payment only if Your Booklet is in effect at the time such services are provided.

Guaranteed Renewable

Coverage under this Booklet is guaranteed renewable, except as permitted to be terminated, cancelled, rescinded, or not renewed under applicable state and federal law. The Member may renew this Booklet by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria continues to be met;

2) There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this coverage; and

3) Membership has not been terminated by Us under the terms of this Booklet.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish any information requested regarding Your eligibility and the eligibility of Your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) Years after the Effective Date of this Booklet, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that You or Your covered Dependents did not disclose on the application, We may terminate or rescind this Booklet as of the original Effective Date. Additionally, if within two (2) Years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that You or Your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give You at least 30 days written notice prior to rescission of this Booklet.

This Booklet may also be terminated if You engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if You knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Booklet. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate Your Dependent's coverage, effective on the date Your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Co-insurance made or Premium paid for such services. After the two (2) years following Your Effective Date, We may only rescind or terminate Your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew Your Booklet if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide You such advance notice of the discontinuation as required by applicable law. In addition, You will be given the option to purchase any health coverage Policy that We currently offer without regard to claims status or health history. Discontinuation will not affect an existing claim.

After Termination

Once this Booklet is terminated, the former Members cannot reapply until the next annual open enrollment unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Grace Period

This Booklet has a 31-day Grace Period. This means if any Premium, except the first, is not paid by its payment due date, it may be paid during the next 31 days. During the grace period, the Booklet will stay in force unless prior to the date the Premium payment is due and You give timely written notice to Us that the Booklet is to be terminated. If You do not make the full Premium payment during the grace period, the Booklet will be terminated on the last day of the Grace Period. You will be liable to Us for the Premium payments due including those for the Grace Period.

Removal of Members

A Subscriber may terminate the enrollment of any Member from the Booklet. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

What We Will Pay for After Termination

Except as provided below, We will not pay for any services provided after the Member's coverage ends even if Preauthorization was received, unless eligibility was verified by the Provider within two business days prior to each service received. Benefits cease on the date the Member's coverage ends as described above. A Member may be liable for benefit payments made by Us on behalf of the Member for services provided after the Member's coverage has terminated, even if the termination was retroactive.

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

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

SECTION 13. APPEALS AND COMPLAINTS

We may have turned down Your claim for benefits, denied a request to cover a Drug as an exception to the Prescription Drug List or determined You were not initially eligible for coverage under this plan. We may have also denied Your request to preauthorize or receive a service or a supply. If You disagree with Our decision You can:

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

Complaints

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

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

Complaints can be made about many things such as customer service, claims administration, benefit determination, eligibility, quality of care, access to Providers, network adequacy, etc. Some descriptions are very narrow. If Your complaint isn't solved either by writing or calling, or if You don't want to file a complaint, You can file an appeal. We'll tell You how to do that next, in the Appeals section below.

Appeals

It's best to file Your appeal within 60 days of getting a denial. The absolute cut-off date for filing an appeal is 180 days from the day You were denied. You can appeal denials that were made either before You received service or after You received service. You can send an appeal in writing to:

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

You don't have to file a complaint before You file an appeal. In Your appeal, please state as plainly as possible why You think We shouldn't have denied Your claim for benefits or eligibility. Include any documents You didn't submit with the original claim or service/supply request. Also send any other documents that support Your appeal. Also, if Your claim was denied because of Utilization Review, You may request independent external review.

You don't have to file the appeal yourself. Someone else, like Your Doctor or another representative can file an appeal for You. Just let Us know in writing who will be filing the appeal for You.

Internal appeals

An internal appeal will be reviewed by a person, who may be on Our staff, but who wasn't involved in the denial. They may get information from co-workers or others who did make the decision. Where the decision is based on Utilization Review, the internal appeal will involve a review by (or a discussion with) a person in the same medical specialty as the case being reviewed. You can be present for the appeal, along with Your counsel, advocates or health care professionals.

Unless You ask for or agree to a longer period, You'll get an answer to Your appeal within 30 days from when We got Your appeal request. But for appeals of services that were already performed, and which did not involve a denial based on Utilization Review, We'll answer the appeal in 60 days.

Expedited appeal

You or Your representative can ask for an expedited appeal if You had Emergency Services but haven't been discharged from the facility. Also, You can ask for an expedited appeal if the regular appeal schedule would do one of the following:

- Seriously jeopardize Your life or health;
- Jeopardize Your ability to regain maximum function;
- Create an immediate and substantial limitation on Your ability to live independently, if You're disabled;
- In the opinion of a Doctor with knowledge of Your condition, would subject You to severe pain that can't be adequately managed without the service in question; or
- But expedited appeals are not available for denials made after the service has been provided.

Your request doesn't have to be in writing and can be made orally. We'll try to make the decision as soon as We can. But it won't take more than 72 hours. The reviewers won't be the people who denied Your claim before. If You don't agree with the appeal decision, You can request an independent external review.

Independent external review appeals

For claims based on Utilization Review, a rescission, or retroactive cancellation of coverage for reasons other than non-payment of premium, or a denial of a request to cover a Drug as an exception to the Prescription Drug List, You can request an independent external review appeal. For these appeals, Your case is reviewed by an external review entity, selected by the Colorado Division of Insurance.

If You want to request an independent external review, You have to fill out a form. It's called the Request for Independent External Review of Carrier's Final Adverse Determination Form. (Your representative can fill it out for You too.) You can get the form from Our Customer Service Department. Once it's filled out, You need to send it to Us.

You can ask for an independent external review within 4 months of Your receipt of Our appeal decision.

Expedited independent external review appeal

You or Your representative can request an expedited independent external review, but only in certain cases:

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

using accepted protocols demonstrate that the requested service is likely to be more beneficial to You than any available standard services.

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

Grievances

You may send a written grievance to:

Anthem
Quality Management Department
700 Broadway
Mail Stop CO0104-0430
Denver, CO 80273-0001

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

Division of Insurance Inquiries

If You have a question about health care coverage in Colorado, please call the Division of Insurance at (303) 894-7490. Representatives will speak with You Monday through Friday, from 8:00 a.m. to 5:00 p.m. You can also write to:

The Division of Insurance
Attention ICARE Section
1560 Broadway, Suite 850
Denver, Colorado 80202

Binding Arbitration

If the dollar amount of Your dispute with Anthem goes above the limit of Small Claims court, then Your case will be decided by Binding Arbitration. If it does, You and Anthem give up the right to have the dispute decided in court. To be arbitrated, a case must first go through all the mandatory levels of appeal and review outlined in this Booklet. Arbitration cases are governed by the rules of the American Arbitration Association. Disputes are governed by the laws of the State where the policy was issued and delivered to the Subscriber. Arbitration rulings are binding on You and Anthem. The award can be reviewed and enforced by any court with proper jurisdiction. If anyone starts a lawsuit or other legal action, the other party may ask a court of competent jurisdiction to forbid, stop or dismiss the action and order the parties to follow the arbitration steps presented here. An arbitrator will decide whether any dispute falls under the arbitration clause.

Legal Action

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

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

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

Please refer to the Section "Prescription Drug List" for the process for submitting an exception request for Drugs not on the Prescription Drug List.

SECTION 14. INFORMATION ON POLICY AND RATE CHANGES

Insurance Premiums

How Premiums are Established and Changed - Premiums are the monthly charges the Member must pay Us to establish and maintain coverage. The Premium for this Booklet may change subject to, and as permitted by, applicable law.

We determine and establish the required Premiums based on age, family size and geographic location. In the event of a change in residence, there may be a change in Premiums, without prior written notice from Us. Such change in Premiums will be effective on the next billing date following Our receipt of written notification of the change of residence. If the Member does not notify Us of a change in residence and We later learn of the change in residential address, We may in Our discretion bill the Member for the difference in Premium from the date the address changed. We are not required to notify the Member of a Premium increase when a Member enters into a new age bracket. In all other instances, We reserve the right to change the Premiums on thirty (30) days written notice to the Subscriber. The change will become effective on the date shown in the notice and payment of the new charges will indicate acceptance of the change in Premium amount.

Exchange Fees or Similar Assessments: In addition, You will be responsible for any charge necessary to recover any assessment billed for Exchange fees or any similar State or federal program. This amount is separate from and in addition to the Premium charges under this Booklet. Failure to pay this charge may result in termination of Your policy, subject to the terms herein.

***Electronic Check / Electronic Funds Transfer:** If the Member receives billing statements by mail and submits a personal check for Premium payments, the Member automatically authorizes Us to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. The Member's payment will be listed on the Member's bank or credit union account statement as an Electronic Funds Transfer (EFT). Converting the Member's paper check into an electronic payment does not authorize Us to deduct Premiums from Your account on a monthly basis unless the Member has given Us prior authorization to do so.

An administrative fee of $20 will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Us for any reason.

Note: We may offer incentives to Members who enroll to automatically pay Premiums electronically instead of receiving a paper bill every month.

Important: If enrolled in our automatic deduction program, the Member must give Us thirty (30) days advance written notice to:

- Change financial institutions
- Change account numbers
- Change account names
- Stop deduction or
- Make any update or re-start eligible deductions

For the above listed changes, a new authorization form is required. We will be happy to send the Member the necessary form upon request by calling the Customer Service phone number on the back of Your Identification Card.

It is the Subscriber's responsibility to pay Premiums to Us. Under no circumstances will Premium payments made on any Member's behalf or any Member be accepted from a Physician, a Hospital or any other Provider of the Subscriber's health care services or any federal or State agency. The receipt of a Premium payment from such a Provider or agency may result in termination of the Subscriber's coverage.

The Subscriber must notify Us of an address change at least thirty (30) days in advance of the Premium due date on which it is to be effective, by submitting an Enrollment Application or Change of Coverage Application. If We do not receive the Member's written request at least thirty (30) days in advance of the Premium due date, We will not be able to make the requested change in time to coincide with the Member's Premium due date. Failure to receive a Premium notice due to an unreported or untimely reported, address change (or any other reason) does not relieve the Member from the responsibility to pay required Premiums by the Premium due date.

Unpaid Premium: Upon the payment of a claim under this Booklet, any Premium then due and unpaid or covered by any note or written order may be deducted therefrom.

SECTION 15. DEFINITIONS

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

Alcohol Dependency: A condition in which You use alcohol in a way that damages Your health or lose Your ability to control Your actions.

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

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

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

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

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

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

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

Balance Billing: When a Provider bills You for the difference between the Provider's charge and the allowed amount. For example, if the Provider's charge is $100 and the allowed amount is $70, the Provider may bill You for the remaining $30. An In-Network Provider may not balance bill You for Covered Services.

Benefit Period: The Benefit Period for this plan begins on Your Effective Date and continues until December 31 of that Year. Later Benefit Periods are for a one Year period which start and end on succeeding calendar Years.

Benefit Period Maximum: The maximum number of days, visits, or dollar amount that 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 and without any adjustment for In-Network Provider or other discounts.

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

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

Brand Name Drug (Brand): The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Cardiac Rehabilitation: Medically supervised program to resume Your activities of daily living after a heart attack.

Case Management: Programs to help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions.

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

Clinical Trial: The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

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

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Co-insurance plus any Deductibles You owe. For example, if the health insurance or plan′s allowed amount for an office visit is $100 and You've met Your Deductible, Your Co-insurance payment of 20% would be $20. Your Co-insurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Complications of Pregnancy means:

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

- Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

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

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

Copayment: A fixed amount (for example, $15) You pay for a covered health care service, usually when You receive the service. The amount can vary by the type of covered health care service.

Cosmetic: Services to keep, change or improve Your appearance or are done for mental reasons.

Cost Share (Cost Sharing): The term used for out-of-pocket costs You pay, for example Copayments, Co-insurance and Deductibles paid by You.

Covered Services: Services, supplies or treatments which are:

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

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

Deductible: Is the dollar amount of Covered Services, listed in the Summary of Benefits, You pay in a Benefit Period before this plan will pay for any remaining Covered Services during that Benefit Period.

Dentally Necessary Orthodontic Care: A service for pediatric members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Dentally Necessary Orthodontic Care to be covered. See the Dentally Necessary Orthodontic Care benefit description in the BENEFITS/COVERAGE (WHAT IS COVERED) section for more information.

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

Domestic Partner: Is a person, other than a Spouse, with whom one cohabits. A Domestic Partner is only eligible for coverage if: he or she has been the Subscriber's sole Domestic Partner for 12 months or more; is mentally competent; is at least 18 years old; is not related to the Subscriber in any way (including by blood or adoption) that would prohibit marriage under State law; is not married to or separated from anyone else; and is financially interdependent with the Subscriber.

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

Effective Date: The date coverage under this Booklet begins.

Emergency or Emergency Medical Condition: Means a medical condition that manifests itself by acute symptoms of sufficient severity, severe pain, that a prudent layperson, with an average knowledge of health and medicine could reasonably expect, in the absence of immediate medical attention, to result in:

- placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy.
- serious impairment to bodily functions or
- serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition, means:

- A medical screening examination (as required under federal law) that is within the capability of the Emergency department of a Hospital, including Ancillary Services routinely available to the Emergency department to evaluate such Emergency Medical Condition, and
- Within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required under federal law to Stabilize the patient.

Experimental or Investigational:

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

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

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

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other State or federal regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use;

- Is provided as part of a clinical research protocol or Clinical Trial (except as noted in the Clinical Trials section under Covered Services in this Booklet as required by State law), or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental or Investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

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

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

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

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

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

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

Family Membership: A membership that covers 2 or more persons (the Subscriber and one or more Dependents).

Formulary / Prescription Drug List: The term Formulary means a listing of Prescription Drugs that are determined by Us in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Us in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for Our other products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Us. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

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

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

Home Delivery Pharmacy: A service where You get Prescription Drugs (other than Specialty Pharmacy Drugs) through a mail order service.

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

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

Hospice Care: A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the State or locality in which it operates.

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

Identification Card: The card We give You that shows Your Member identification, group number, and the plan You have.

In-Network Provider: A Provider that has a contract, either directly or indirectly, with Us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

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

Maintenance Medication: Is a Drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure if the Prescription Drug You are taking is a Maintenance Medication, please call Customer Service at the number on the back of Your Identification Card or check Our website at www.anthem.com for more details.

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

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

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

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

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

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

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

Member: The Subscriber or any Dependent who is enrolled for coverage under this Booklet. Also referred to in this Booklet as "You" or "Your".

Mental Health and Substance Abuse: Is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition. It does not include autism or pervasive developmental disorders, which under State law are considered medical conditions.

Minimum Essential Coverage: The term means any of the following: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health, or benefits risk pool.

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

Orthotic: A support or brace for weak or ineffective joints or muscles.

Out-of-Network Provider: A Provider that does not have an agreement or contract with Us, or Our Subcontractor(s) to give services to Our Members. You will often get a lower level of benefits when You use Out-of-Network Providers.

Out-of-Pocket Annual Maximum: A specified dollar amount of expense incurred for Covered Services in a calendar Year as listed in the Summary of Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Benefits for other services that may not be included in the Out-of-Pocket Annual Maximum. When the Out-of-Pocket Annual Maximum is reached, no additional Cost Sharing is required unless otherwise specified in this Booklet.

Participating Pharmacy: The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Ours at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for Our other products. To find a Participating Pharmacy near You, contact the Customer Service telephone number on the back of Your Identification Card.

Pharmacy: The term Pharmacy means a place licensed by State law where You can get Prescription Drugs and other medicines from a licensed pharmacist when You have a prescription from Your Doctor.

Pharmacy and Therapeutics (P&T) Process: The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help You access quality, low cost medicines within Your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the Anthem National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for Our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, Preauthorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

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

Premium: Monthly charges that You and must pay to establish and maintain coverage.

Prescription Drug (Drug): The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes insulin, diabetic supplies, and syringes.

Primary Care Physician (“PCP”): A Physician who gives or directs health care services for you. The Physician may work in family practice, general practice, internal medicine, pediatrics or any other practice allowed by the plan.

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

Reconstructive Surgery: Includes procedures that are meant to address a major change from normal in relation to Accidental Injury, disease, trauma, treatment of a disease or Congenital Defect.

Retail Pharmacy: A place licensed to dispense Prescription Drugs through a licensed pharmacist due to a Doctor’s order.

Self-Administered Drugs: The term Self-Administered Drugs means drugs that are administered which do not require a medical professional to administer.

Service Area: The geographical area where You can get Covered Services from an In-Network Provider, as approved by State regulatory agencies.

Skilled Nursing Care Facility (SNF): A place that provides You with skilled nursing care, for example therapies and protective supervision if You have an uncontrolled, unstable or chronic condition. Skilled nursing care is provided under medical supervision to carry out nonsurgical treatment of chronic diseases or convalescent stages of acute diseases or injuries. Skilled nursing facilities do not provide You with care for high intensity medical needs, or if You are medically unstable.

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

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

Specialty Drugs: The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at Retail Pharmacies.

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

Specialty Pharmacy: A Pharmacy that is designated by Us, other than a Retail Pharmacy, Home Delivery Pharmacy, or other Specialty Pharmacy that provides high cost, biotech drugs which are usually injected, oral, infused or inhaled and used for the treatment of acute or chronic diseases.

Specialty Pharmacy Drugs: These are high-cost, injectable, infused, oral or inhaled medications as listed on the Specialty Drug List that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at a Retail Pharmacy.

Spouse: A Subscriber's legal Spouse, including Domestic Partner and a partner in a civil union.

Stabilize: Medical treatment You get in an Emergency as may be needed to make sure that material deterioration of Your condition is not likely to result from or during:

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

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

Subscriber: Is the individual who signed the Application of Coverage and in whose name the Identification Card is issued.

Substance Dependency: A condition which You use drugs and other substances in a manner that damages Your health or loses Your ability to control Your actions.

Surgery: Any variety of technical procedures for treatment or diagnosis of anatomical disease or injury, such as cutting, micro Surgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, and other invasive procedures. Covered surgical services also include Anesthesia and pre- and post-operative care, including recasting.

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

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

Tier One Drugs: This tier includes low cost and preferred Drugs that may be Generic, single source Brand Drugs, or multi-source Brand Drugs.

Tier Two Drugs: This tier includes preferred Drugs considered Generic, single source Brand Drugs, or multi-source Brand Drugs.

Tier Three Drugs: This tier includes Drugs considered Generic, single source Brand Drugs, or multi-source Brand Drugs.

Tier Four Drugs: This tier contains high cost Drugs. This includes Drugs considered Generic, single source Brand Drugs, and multi-source Brand Drugs.

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

Urgent Care Center: An office or facility where care is provided for You in an Urgent Care situation.

Utilization Review: A set of formal techniques to monitor or evaluate the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, care management, discharge planning and/or retrospective review. Utilization Review also includes reviewing whether or not a procedure or treatment is considered Experimental or Investigational, and reviewing Your medical circumstances when such a review is needed to determine if an exclusion applies.

We, Us, Our: Is Anthem.

Year: Is a twelve (12) month period starting each January 1 at 12:01 a.m. Mountain Standard Time.

You and **Your:** Means the Subscriber and any family Members covered under this Booklet.

End of Booklet

Subscriber and Premium Information

Issued by:

Anthem

PLAN NAME: _____

[CONTRACT CODE: _____]

SUBSCRIBER'S NAME:_____

[DEPENDENT'S NAME:_____]

[DEPENDENT'S NAME:_____]

[DEPENDENT'S NAME:_____]

SUBSCRIBER'S [RESIDENTIAL] ADDRESS: _____

MONTHLY PREMIUM RATE: _____

PREMIUM RATE EFFECTIVE DATE: _____

Please review this information carefully and if it is incorrect please inform your agent or Us immediately.

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.