SECTION 1. SCHEDULE OF BENEFITS (Who Pays What)

HMO Colorado

Anthem Bronze Pathway Essentials X HMO 9100 $0 Select Drugs

Outpatient Retail Prescription Drug Copayment Plan

January 1, 2023

This chart is an overview of Your benefits for Covered Services, which are listed in detail in the "Section 7. Benefits/Coverage (What is Covered)" section. A list of services that are not covered can be found in the "Section 8. Limitations/Exclusions (What is Not Covered)" section.

Services by Providers located outside Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson or Park counties of the State of Colorado will only be Covered Services if:

- The services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center ; or
- The services are approved in advance by HMO Colorado.

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 HMO Colorado has many contracting Providers who may not be part of the network of Providers that applies to this Plan.

HMO Colorado can help You find an In-Network Provider specific to Your Plan by calling the number on the back of Your Identification Card.

What will I pay?

Reimbursement for Covered Services is based on the Maximum Allowed Amount, which is the most Your Certificate will allow for a Covered Service.

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 a detailed explanation of how Your Deductibles and Out-of-Pocket Maximums are calculated, see the "Member Payment Responsibility" section. Except for Surprise Billing Claims, when You receive Covered Services from an Out-of-Network Provider, You may also be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges.

Plan Features

Deductible	In-Network Member Pays	Out-of-Network Member Pays
Individual	$9,100	Not Covered
Family	$18,200	Not Covered

Embedded Deductible:

The individual Deductible applies to each covered family Member. No one person can contribute more than the 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 "Member Payment Responsibility" section for more details

Coinsurance	In-Network Member Pays	Out-of-Network Member Pays
Coinsurance Percentage Unless specified otherwise below	0% Coinsurance	Not Covered

Out-of-Pocket Maximum	In-Network Member Pays	Out-of-Network Member Pays
Individual	$9,100	Not Covered
Family	$18,200	Not Covered

Embedded Out-of-Pocket Maximum :

The individual Out-of-Pocket Maximum applies to each covered family Member. Once two or more covered family Members' Out-of-Pocket Maximum combine to equal the family Out-of-Pocket Maximum amount, the Out-of-Pocket Maximum will be satisfied for the family for that Calendar Year.

Medical Services

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Ambulance Services **Emergency**	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance
Nonemergency If Pre-certified by Us, Out-of-Network nonemergency ambulance services are subject to the same Cost Share as In-Network services up to $50,000 per occurrence. In addition to Your Cost Share, You will be responsible for amounts over the Maximum Allowed Amount except for air ambulance services	$0 Copayment 0% Coinsurance	Not Covered
Autism Spectrum Disorders Includes Applied Behavioral Analysis Services through age 18	Cost Share determined by place of service and the Covered Service received	Not Covered
Dental Services When provided for accidental injury or for certain Members requiring general anesthesia	Cost Share determined by place of service and the Covered Service received	Not Covered
Diabetes Services Includes Outpatient-self management training, supplies, equipment and education	Some services, education and supplies may be exempt from Cost Share, otherwise, Cost Share determined by place of service and the Covered Service received	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Diagnostic Services; Outpatient		
Diagnostic Laboratory and Pathology Services Includes testing and treatment of COVID-19, as required under any applicable federal or State law.	$0 Copayment 0% Coinsurance	Not Covered
Diagnostic Imaging Services and Electronic Diagnostic Tests	$0 Copayment 0% Coinsurance	Not Covered
Advanced Imaging Services	$0 Copayment 0% Coinsurance	Not Covered
Doctor (Physician) Visits		Not Covered
Office Visits with: • Primary Care Physician (PCP) • Retail Health Clinic, includes all Covered Services received at a Retail Health Clinic	First 3 visits per Member per Calendar Year: Deductible does not apply; $50 Copayment 0% Coinsurance All subsequent visits: $0 Copayment 0% Coinsurance	
Virtual Visits with PCP The office visit Copayment limit is combined for the visits with Providers/services listed above	First 3 visits per Member per Calendar Year: Deductible does not apply; $50 Copayment 0% Coinsurance All subsequent visits: $0 Copayment 0% Coinsurance	Not Covered
Virtual Visits with PCP from Our	Deductible does not apply; $0 Copayment	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Online Provider, LiveHealth Online (whether accessed directly or through Our mobile app, website, or HMO Colorado-enabled devices)	0% Coinsurance	
Specialty Care Physician (SCP) (including in-person and/or Virtual Visits)	$0 Copayment 0% Coinsurance	Not Covered
Medical Chats and Virtual Visits (including primary care) from Our online Provider K Health, through its affiliated Provider groups, in Our mobile app	Deductible does not apply; $0 Copayment 0% Coinsurance	Not Covered
Other Office Services Includes testing and treatment of COVID-19, as required under any applicable federal or State law.	$0 Copayment 0% Coinsurance	Not Covered
Emergency Room Visits Additional Cost Share determined based on service received	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance For Covered Emergency Services from an Out-of-Network Provider at a Facility in Colorado, You are not responsible for the charges over the Plan's Maximum Allowed Amount.
Home Care Services Limited to a maximum of 28 hours per Member per week	$0 Copayment 0% Coinsurance	Not Covered
Hospice Care	$0 Copayment 0% Coinsurance	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Hospital Services **Inpatient Facility**	$0 Copayment 0% Coinsurance	Not Covered
Outpatient Facility	$0 Copayment 0% Coinsurance	Not Covered
Inpatient and Outpatient Professional Services	$0 Copayment 0% Coinsurance	Not Covered
Medical Supplies, Durable Medical Equipment and Appliances		
Hearing Aids Initial and replacement hearing aids will be supplied every five Years for Members under 18 years of age. New hearing aid will be a Covered Service when alterations to Your existing hearing aid cannot adequately meet Your needs or be repaired	$0 Copayment 0% Coinsurance	Not Covered
Prosthetics Prosthetic devices, their repair, fitting, replacement and components. For prosthetic arms and legs, We cover up to the benefits amounts provided by federal laws for Medicare or where	$0 Copayment 0% Coinsurance	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
needed to meet State insurance laws.		
Mental Health and Substance Abuse Services		
Inpatient Facility including Residential Treatment	$0 Copayment 0% Coinsurance	Not Covered
Outpatient Facility including partial hospitalization or intensive Outpatient For Cost Share related to Outpatient professional services, including office visits, and PCP Virtual Visits, please see Doctor (Physician) Visits and Specialty Care Physician services listed above.	$0 Copayment 0% Coinsurance	Not Covered
Physical Medicine and Rehabilitation		
Inpatient Facility	$0 Copayment 0% Coinsurance	Not Covered
Outpatient Facility	$0 Copayment 0% Coinsurance	Not Covered
Inpatient and Outpatient Professional Services Limited to a maximum of two months of therapy per Member, per Calendar Year **Note**: For Outpatient therapy limits, see the “Therapy Services - Outpatient” section	$0 Copayment 0% Coinsurance	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
To the extent required by applicable law, the Cost Share for certain In-Network Outpatient therapy services will equal the non-preventive In-Network PCP Cost Share		
Preventive Care Services In-Network services required by law are not subject to Deductible	Deductible does not apply; $0 Copayment 0% Coinsurance	Not Covered
Skilled Nursing Facility Limited to a maximum of 100 days per Member, per Calendar Year	$0 Copayment 0% Coinsurance	Not Covered
Surgery **Ambulatory Surgical Center**	$0 Copayment 0% Coinsurance	Not Covered
Therapy Services - Outpatient Includes coverage for Chemotherapy, Occupational, Physical, Radiation, Respiratory and Speech Therapies Outpatient Habilitative and Rehabilitative Therapy Services (limits on Physical, Occupational and Speech Therapy services listed below are not combined but separate based on determination of Habilitative Service or Rehabilitative Service). The limits do not apply to Mental Health and Substance Abuse conditions		

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Acupuncture Acupuncture and acupressure treatment limited to a combined maximum of 6 visits per Member per Calendar Yearwill be covered to the extent required by law	First 3 visits per Member per Calendar Year: Deductible does not apply; $50 Copayment 0% Coinsurance All subsequent visits: $0 Copayment 0% Coinsurance	Not Covered
Cardiac Rehabilitation	$0 Copayment 0% Coinsurance	Not Covered
Early Intervention Services Limited to a maximum of 45 visits per Member per Calendar Year	$0 Copayment 0% Coinsurance	Not Covered
Manipulation Therapy Limited to a maximum of 20 visits per Member, per Calendar Year	First 3 visits per Member per Calendar Year: Deductible does not apply; $50 Copayment 0% Coinsurance All subsequent visits: $0 Copayment 0% Coinsurance	Not Covered
Occupational Therapy Limited to a maximum of 20 visits per Member, per Calendar Year	First 3 visits per Member per Calendar Year: Deductible does not apply; $50 Copayment 0% Coinsurance All subsequent visits: $0 Copayment 0% Coinsurance	Not Covered
Physical Therapy Limited to a maximum of 20 visits per Member, per Calendar Year	First 3 visits per Member per Calendar Year: Deductible does not apply; $50 Copayment 0% Coinsurance All subsequent visits: $0 Copayment	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Speech Therapy Limited to a maximum of 20 visits per Member, per Calendar Year	0% Coinsurance First 3 visits per Member per Calendar Year: Deductible does not apply; $50 Copayment 0% Coinsurance All subsequent visits: $0 Copayment 0% Coinsurance	Not Covered
Pulmonary Rehabilitation When rendered in the home, home healthcare limits apply. If part of physical therapy, the physical therapy limit will apply	$0 Copayment 0% Coinsurance	Not Covered
Prevention of Substance Abuse Services Limited to 6 visits each of Acupuncture, Occupational, Physical and Manipulation Therapies when used for non-pharmacological treatment of a patient with a pain diagnosis, where an opioid might be prescribed. These visits are combined with and subject to the therapy service limits listed above	To the extent required by applicable law, the Cost Share for certain In-Network Outpatient therapy services will equal the non-preventive In-Network PCP Cost Share	Not Covered
Transplant Human Organ and Bone Marrow/Stem Cell/Cord Blood **Unrelated Donor Search** Limited to a maximum of the 10 best matched donors per transplant, identified by an	Cost Share determined by place of service and the Covered Service received Living organ donor expenses will be covered at the Cost Share, if any, required by applicable law	Not Covered

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
authorized registry. This limitation does not apply to living organ transplants in which case donor costs will be covered to the extent required by applicable law		
Urgent Care Center Additional Cost Share determined based on service received	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance

Prescription Drugs

Your Plan has two levels of coverage. To get the lowest out-of-pocket cost, You must get Covered Services from a Level 1 In-Network Pharmacy. If You get Covered Services from any other In-Network Pharmacy, benefits will be covered at Level 2 and You may pay more in Deductible, Copayments, and Coinsurance.

Level 1 In-Network Pharmacies. When You go to Level 1 In-Network Pharmacies, (also referred to as Core Pharmacies), You pay a lower Copayment / Coinsurance on Covered Services than when You go to other In-Network Providers.

Level 2 In-Network Pharmacies. When You go to Level 2 In-Network Pharmacies, (also referred to as Wrap Pharmacies), You pay a higher Copayment / Coinsurance on Covered Services than when You go to a Level 1 In-Network Pharmacy.

Retail Pharmacy Prescription Drugs	**In-Network** **Member Pays Level 1 Pharmacy**	**In-Network** **Member Pays Level 2 Pharmacy**	**Out-of-Network Member Pays**
Tier 1 (30-day supply)	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance	Not Covered
Tier 2 (30-day supply)	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance	Not Covered
Tier 3 (30-day supply)	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance	Not Covered
Tier 4 (30-day supply)	$0 Copayment 0% Coinsurance	$0 Copayment 0% Coinsurance	Not Covered

Notes:

The per Member per prescription Cost Share will not exceed $20 for a Prescription Drug that contains insulin that is used to treat diabetes, when obtained In-Network and for a 30 day supply or less. The per Member Cost Share for a 30 day supply of a Prescription Drug that contains insulin and is used to treat diabetes, will not exceed a total of $100 per 30 day supply or $300 per 90 day supply, when obtained In-Network. Deductible does not apply.

Retail Pharmacy is limited to a 30-day supply per Prescription.

Specialty Drugs must be purchased from the Pharmacy Benefits Manager's Specialty Pharmacy.

Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

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, if services are provided by an In-Network Provider.

A Prescription contraceptive provided by an In-Network Pharmacy can be dispensed to a Member in a three-month supply for the first dispensing. It can be dispensed for a 12-month supply for subsequent dispensings of the same prescription contraceptive or through the end of the Member's coverage under this policy. In case of vaginal contraceptive rings, it can be dispensed intended to last for three months.

Prescription Drugs under "Preventive Care Services" that require coverage under federal law, will be covered with no Deductible, Copayments or Coinsurance when You use an In-Network Provider.

To the extent required by applicable law, Prescription Drug coverage will include at least one drug in every United States Pharmacopeia (USP) category and class, or the same number of Prescription Drugs in each category and class as the EHB-benchmark plan.

Home Delivery Prescription Drugs	In-Network Member Pays	Out-of-Network Member Pays
Tier 1 (90-day supply)	$0 Copayment 0% Coinsurance	Not Covered
Tier 2 (90-day supply)	$0 Copayment 0% Coinsurance	Not Covered
Tier 3 (90-day supply)	$0 Copayment 0% Coinsurance	Not Covered
Tier 4 (30-day supply)	$0 Copayment 0% Coinsurance	Not Covered

Notes:

For a home delivery Prescription Drug that contains insulin, for a supply in excess of 30 days, the per Member Cost Share will not exceed a total of $100 per 30 day supply or $300 per 90 day supply. Deductible does not apply.

Specialty Drugs must be purchased from the Pharmacy Benefits Manager's Specialty Pharmacy and are limited to a 30-day supply.

Coverage is limited to those drugs listed on Our Prescription Drug List (formulary).

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, if services are provided by an In-Network Provider.

Home Delivery Prescription Drugs	In-Network Member Pays	Out-of-Network Member Pays
A Prescription contraceptive provided by an In-Network Pharmacy can be dispensed to a Member in a three-month supply for the first dispensing. It can be dispensed for a 12-month supply for subsequent dispensings of the same prescription contraceptive or through the end of the Member's coverage under this policy. In case of vaginal contraceptive rings, it can be dispensed intended to last for three months. Prescription Drugs under "Preventive Care Services" that require coverage under federal law, will be covered with no Deductible, Copayments or Coinsurance when You use an In-Network Provider.		

Pediatric Dental Services

The following pediatric dental services are covered for Members until the end of the month in which they turn 19.

Covered Dental Services, unless otherwise stated below, are subject to the same Benefit Period Deductible and Out-of-Pocket Maximum as medical and amounts can be found on the first page of this Schedule of Benefits (Who Pays What).

Please see Pediatric Dental Care in the “Benefits/Coverage (What is Covered)” section for more information on pediatric dental services.

Pediatric Dental Care	In-Network Member Pays	Out-of-Network Member Pays
Diagnostic and Preventive Services	0% Coinsurance	Not Covered
Basic Restorative Services	0% Coinsurance	Not Covered
Oral Surgery Services	0% Coinsurance	Not Covered
Endodontic Services	0% Coinsurance	Not Covered
Major Restorative Services	0% Coinsurance	Not Covered
Dentally Necessary Orthodontic Care Services	0% Coinsurance	Not Covered

Pediatric Vision Services

The following vision care services are covered for Members until the end of the month in which they turn 19.

Please see Pediatric Vision Care in the "Benefits/Coverage (What is Covered)" section for more information on pediatric vision services.

Covered vision services are **not** subject to the Benefit Period Deductible.

Covered Vision Services	In-Network Member Pays	Out-of-Network Member Pays
Routine Eye Exam Covered once per Benefit Period per Member	$0 Copayment	Not Covered
Standard Plastic Lenses One set of lenses covered per Benefit Period per Member.		
Single Vision	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Progressive	$0 Copayment	Not Covered
Additional Lens Options Covered lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic at no additional cost when received from In-Network providers.		
Frames (formulary) One frame covered per Benefit Period per Member.	$0 Copayment	Not Covered
Contact Lenses (formulary) Elective or non-elective contact lenses are covered once per Benefit Period per Member.		
Elective (conventional and disposable)	$0 Copayment	Not Covered
Non-Elective	$0 Copayment	Not Covered
Important Note: Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next Calendar Year.		

Eligible American Indians, as determined by the Exchange, are exempt from Cost Sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through Referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these Providers.

SECTION 2. TITLE PAGE (Cover Page)

Anthem Bronze Pathway Essentials X HMO 9100 $0 Select Drugs

Outpatient Retail Prescription Drug Copayment Plan

Offered by HMO Colorado

HMO Colorado
P.O. Box 5747
Denver, CO 80217-5747

RIGHT TO EXAMINE

If this Certificate is provided to You as a new Subscriber, You have 10 days to review this Certificate to make sure that You are satisfied with the product You selected. If You are not satisfied, return this Certificate 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 healthcare coverage. We wish You good health.

SECTION 3. CONTACT US

We are pleased that You have become a Member of Our health Plan, where it's Our mission to improve the health of the people We serve. We've designed this Certificate to give a clear description of Your benefits, as well as Our rules and procedures.

This Certificate explains many of the rights and duties between You and Us. It also describes how to get healthcare, what services are covered, and what part of the costs You will need to pay. Many parts of this Certificate are related. Therefore, reading just one or two sections may not give You a full understanding of Your coverage. You should read the whole Certificate to know the terms of Your coverage.

This Certificate and the application shall constitute the entire contract under which Covered Services and supplies are provided by Us.

Many words used in the Certificate have special meanings (e.g., Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Certificate You will also see references to "We," "Us," "Our," "You," and "Your." The words "We," "Us," and "Our" mean HMO Colorado. The words "You" and "Your" mean the Member, Subscriber and each covered Dependent.

If You have any questions about Your Plan, please be sure to call Member Service at the number on the back of Your Identification Card. Also be sure to check Our website, www.anthem.com for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank You again for enrolling in the Plan!

Charles Ritz
Colorado President
HMO Colorado

How to obtain Language Assistance

HMO Colorado is committed to communicating with Our Members about their health Plan, no matter what their language is. HMO Colorado employs a language line interpretation service for use by all of Our Member Services call centers. Simply call the Member Services 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 Member Services. Teletypewriter/Telecommunications Device for the Deaf (TTY/TDD) services are also 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 Member Services number.)

Identity Protection Services

Identity protection services are available with Our HMO Colorado health Plans. To learn more about these services, please visit https://anthemcares.allclearid.com/.

Contact Us

Member Services is available to explain policies and procedures, and answer questions regarding the availability of benefits.

For information and assistance, a Member may call or write HMO Colorado

The telephone number for Member Services is 1-855-453-7031. The address is:

HMO Colorado
Member Services 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. Mountain Time

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

Health benefit coverage is defined in the following documents:

- This Certificate and the "Schedule of Benefits (Who Pays What);"
- The Colorado individual enrollment application form and any other application from You or Your Dependents; and
- Your Identification Card.

HMO Colorado, or someone on Our behalf, will determine how benefits will be managed and who is eligible under this Certificate. If any question comes up about any terms of this Certificate, 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 Certificate.

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

Conformity with Law

Conformity with State Statutes: Any provision of this Certificate 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.

Acknowledgement of Understanding

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

Delivery of Documents

We will provide an Identification Card and Certificate for each Subscriber.

HMO Colorado Disclosure

Pursuant to Colorado law (C.R.S §10-16-105.1), 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.

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician

We allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in Our network and who is available to accept You or Your family Members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of Your Identification Card or refer to Our website, www.anthem.com. For children, You may designate a pediatrician as the PCP.

Access to Obstetrical and Gynecological (OB/GYN) Care

You do not need prior authorization from Us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a healthcare professional in Our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, or procedures for making Referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or refer to Our website, www.anthem.com.

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Act as well the Provider transparency requirements that are described below.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network air ambulance services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under Your Plan:

- Without the need for Precertification;
- Whether the Provider is In-Network or Out-of-Network.

If the Emergency Services You receive are provided by an Out-of-Network Provider, Covered Services will be processed at the In-Network benefit level

Note that if You receive Emergency Services from an Out-of-Network Provider, Your out-of-pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, if the treating Out-of-Network Provider determines You are stable, meaning You have been provided necessary Emergency Services such that Your condition will not materially worsen and the Out-of-Network Provider determines: (i) that You are able to travel to an In-Network Facility by non-Emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) You are in condition to receive the information and provide informed consent, You will be responsible for all charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at an In-Network Facility

When You receive Covered Services from an Out-of-Network Provider at an In-Network Facility, Your claims will not be covered if the Out-of-Network Provider gives You proper notice of its charges, and You give written consent to such charges. This means You will be responsible for all Out-of-Network charges for those services. This requirement does not apply to Ancillary Services. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) hospitalists; (I) intensivists; and (J) any services set out by the U.S. Department of Health & Human Services. In addition, HMO Colorado will not apply this notice and consent process to You if HMO Colorado does not have an In-Network Provider in Your area who can perform the services You require.

Out-of-Network Providers satisfy the notice and consent requirement as follows:

1) By obtaining Your written consent not later than 72 hours prior to the delivery of services; or

2) If the notice and consent is given on the date of the service, if You make an appointment within 72 hours of the services being delivered.

How Cost Shares Are Calculated

Your Cost Shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that we pay In-Network Providers for the geographic area where the Covered Service is provided. Any out-of-pocket Cost Shares You pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility will be applied to Your In-Network Out-of-Pocket Maximum.

Appeals

If You receive Emergency Services from an Out-of-Network Provider, Covered Services from an Out-of-Network Provider at an In-Network Facility, or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprises Act, You have the right to Appeal that claim. If

Your Appeal of a Surprise Billing Claim is denied, then You have a right to Appeal the adverse decision to an Independent Review Organization as set out in “Appeals and Complaints” section of this Certificate.

Provider Directories

HMO Colorado is required to confirm the list of In-Network Providers in its Provider Directory every 90 days. If You can show that You received inaccurate information from HMO Colorado that a Provider was In-Network on a particular claim, then You will only be liable for In-Network Cost Share (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network Cost Share will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

HMO Colorado provides the following information on its website at www.anthem.com:

- Protections with respect to Surprise Billing Claims by Providers, including information on how to contact State and federal agencies if You believe a Provider has violated the No Surprises Act.

You may also obtain the following information on HMO Colorado’s website or by calling Member Services at the phone number on the back of Your ID Card:

- Cost Sharing information for 500 defined services, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing/directory of all In-Network Providers.

In addition, HMO Colorado will provide access through its website to the following information:

- In-Network negotiated rates; and
- Historical Out-of-Network rates.

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SECTION 5. ELIGIBILITY

The benefits, terms and conditions of this Certificate are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber Eligibility

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

1. Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2. Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic Plan;
3. Be a United States citizen or national; or
4. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5. Be a resident of the State of Colorado and meet the following applicable residency requirements:

For a Qualified Individual age 21 and over, the applicant must:

- Not be living in an institution;
- Be capable of indicating intent;
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area applicable to this Certificate.

For a Qualified Individual under age 21, the applicant must:

- Not be living in an institution;
- Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security;
- Not be emancipated;
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area applicable to this Certificate.

6. Agree to pay for the cost of the Premium that We require;
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
8. Not be incarcerated (except pending disposition of charges);
9. Not be entitled to or enrolled in Medicare Parts A/B, C and/or D;
10. Not be covered by any other group or individual health benefit plan.

For purposes of eligibility, a Qualified Individual's Service Area is the area in which the Qualified Individual:

1. resides, intends to reside (including without a fixed address); or
2. is seeking employment (whether or not currently employed); or
3. has entered with a job commitment.

For Qualified Individuals under age 21, the Service Area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with members in multiple Exchange Service Areas:

1. If all of the members of a tax household are not living within the same Exchange Service Area, any member of the tax household may enroll in a Qualified Health Plan (QHP) through any of the Exchanges for which one of the Tax Filers meets the residency requirements.
2. If both spouses in a tax household enroll in a Qualified Health Plan (QHP) through the same Exchange, a Tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets residency requirements.

Dependent Eligibility

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

1. The Subscriber's legal spouse. This includes the partner to a civil union, if recognized as a spousal relationship in the State where the Subscriber lives; or
2. The Subscriber's domestic partner - domestic partner or domestic partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole domestic partner and has been for 12 months or more; he or she is mentally competent; neither the Subscriber nor the domestic partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under State law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a. For purposes of this Certificate, 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.
    b. 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.
    c. To apply for coverage as domestic partners, both the Subscriber and the eligible domestic partner are required to complete and sign an enrollment application, meet all criteria stated on the enrollment application and submit the enrollment application to the Exchange.
3. The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26.
4. Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those Dependents who are unmarried and medically certified as impaired and are dependent upon the parent Subscriber. The Exchange must certify the Dependent's eligibility. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

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

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

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

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), during the annual open enrollment period or as an enrollee to add a Qualified Individual to the current QHP during a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in or change a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

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 60 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.

The Exchange must allow Qualified Individuals to enroll in or change a QHP as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, civil union, birth, adoption or placement for adoption, placement in foster care, through a child support order or other court order, or by entering into a designated beneficiary agreement pursuant to Article 22 of Title 15, C.R.S;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for Cost Sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move, provided he or she had Minimum Essential Coverage in effect or lived abroad for one or more days of the 60 days prior to the move; or is an American Indian or Alaskan Native, and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide;
- A Qualified Individual loses pregnancy-related Medicaid coverage. The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage;
- When an Exchange enrollee loses a Dependent or is no longer considered a Dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the Exchange enrollee, or his or her Dependent, dies;
- An individual or his or her Dependent losing other coverage as described under Section 1902(a)(10)(C) of the Social Security Act (42 U.S.C. § 301 et seq.). Such individual or Dependent may apply once during a Calendar Year for enrollment in a new health benefit plan

during the 60 calendar days before and after the effective date of the loss of coverage;

- Any other event or circumstance occurs as set forth in rules established by applicable State law in defining triggering events;
- A parent or legal guardian dis-enrolling a Dependent from, or a Dependent becoming ineligible for coverage under the Children's Basic Health Plan;
- An individual becoming ineligible under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.);
- An Indian, as defined by Section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1601 et seq.), may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month;
- An individual who is a victim of domestic abuse or spousal abandonment, including a Dependent or unmarried victim within a household, who is enrolled in creditable coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment;
- An individual who is a Dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;
- An individual or his or her Dependent who applies for coverage during the annual open enrollment period or due to a qualifying event, and is assessed as potentially eligible for Medicaid or the Child Health Plan Plus (CHP+), and is determined ineligible for Medicaid or CHP+ either after open enrollment has ended or more than 60 days after the triggering or qualifying event, or applies for coverage through the State Medicaid or CHP+ agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHP+ after open enrollment has ended; or
- An individual, or his or her Dependent, adequately demonstrates to the Commissioner (or to the Exchange for on-Exchange plans) that a material error related to Plan benefits, service area, or premium influenced the Qualified Individual's or enrollee's decision to purchase a QHP;
- You or Your spouse experience a decrease in household income that results in eligibility for Advance Payments of the Premium Tax Credit as determined by the Exchange, provided You or Your spouse had Minimum Essential Coverage for one or more days in the 60 days prior to the date of the financial change;
- A Qualified Individual newly gains access to an Individual Coverage Health Reimbursement Arrangement (ICHRA) or is newly provided a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).

In addition, We will allow triggering events and special enrollment periods to the extent required by applicable law. If You cannot find Your situation, contact Your agent/broker or call Us. We can only enroll based on events defined by State and/or federal law.

NOTE: Special enrollment for marriage or civil union - in order to qualify for special enrollment at least one spouse must have been enrolled in a plan that provided Minimum Essential Coverage and was enrolled for at least one day in the 60 days before marriage; or lived abroad for one or more days in the 60 days before marriage; or be an American Indian or Alaskan Native.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. To continue coverage beyond the first 31 days, please contact the Exchange within 60 days of the date of birth to add the child to the Subscriber's policy and You must pay Us timely for any additional Premium due.

All services given during the first 31 days of coverage are subject to the Cost Sharing needs that apply to other sicknesses, diseases and conditions that are covered. This means that the child may have to pay a separate individual Deductible, Copayment and/or Coinsurance for Covered Services.

A child will be considered adopted from the earlier of: (1) placement for adoption; or (2) the date the court enters a decree granting the adoption. 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.

Please contact the Exchange within 60 days of the placement for adoption or date of adoption to add the child to the Subscriber's policy and You must pay Us timely for any additional Premium due.

Adding a Child due to Award of Court-Appointed Guardianship

If a Subscriber or the Subscriber's spouse files an application for appointment of guardianship of a child, an application to cover the child under the Subscriber's policy must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Court Ordered Health Coverage

If You are required by a court order, as defined by applicable State or federal law, to enroll Your child under this Certificate, and the child is otherwise eligible for the coverage, You must request permission from the Exchange for Your child to enroll under this Certificate and once approved by the Exchange, We will provide the benefits of this Certificate 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 Certificate 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 for a Qualified Individual who has made a QHP selection during the annual open enrollment period. Except where noted otherwise, the applicant's Effective Date is determined by the Exchange based on the receipt of the completed enrollment form; forms received between the 1st and 15th will get a first of the next month Effective Date and forms received between the 16th and end of the month will get the first of the second month Effective Date. Benefits will not be provided until the applicable Premium is paid to Us.

Effective Dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, placement in foster care or by court order, coverage is effective on the date of birth, adoption, placement for adoption, placement in foster care or the effective date of the order, unless the Subscriber timely requests a different Effective Date;
2. In the case of marriage or civil union, coverage is effective on the first day of the month after receipt of the application, as long as the application is received within 60 days of the event;
3. In the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the month following the loss of coverage if plan selection occurs before the loss of coverage; otherwise coverage is effective based on when a complete application is received, which must be within 60 days of the qualifying event; and
4. In the case of new access to an ICHRA or new provision of a QSEHRA, if the Plan selection is made before the day of the triggering event, coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the Plan selection is made on or after the day of the triggering event, coverage is effective on the first day of the month following the Plan selection.

Effective Dates for special enrollment due to 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;
6. Individual who no longer resides, lives or works in the Plan's Service Area;
7. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;
8. Termination of employer contributions; or
9. Exhaustion of COBRA or, where applicable, State continuation benefits.

Effective Dates for special enrollment due to loss of Minimum Essential Coverage do not include 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 the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Certificate. The Exchange 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, changes in income, change of Dependent's impairment or dependency status. Failure to notify the Exchange 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 single 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 single coverage. The Exchange must be notified when a Member becomes eligible for or enrolled in Medicare.

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

Statements and Forms

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

Multiple HMO Colorado Coverage

If a Member is covered under this Certificate and is also covered by another HMO Colorado 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 Premiums being refunded.

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

The purpose of this section is to help You understand how to receive the highest level of benefits available under this Plan. It provides details about In-Network Providers who have entered into an agreement with HMO Colorado and Out-of-Network Providers who have not. You will also find information about how to access a list of In-Network Providers in Your Service Area and the importance of choosing a Primary Care Physician.

To find an In-Network Provider for this Plan, please see "How to Find a Provider in the Network" later in this section.

This is a Health Maintenance Organization (HMO) Plan. We have coordinated and contracted with a network of doctors, Hospitals, and support services (e.g., laboratory, x-ray, Pharmacy, and physical therapy) to arrange for or provide total healthcare services to Members. Learning how an HMO works can help You make the best use of Your healthcare benefits. The "Schedule of Benefits (Who Pays What)" lists the out-of-pocket expenses and certain benefit limits You may incur. We try to keep healthcare costs reasonable by working with You, Your doctor, Hospitals, and other Providers together. You and Your Primary Care Physician (PCP) can work together to get care from a Specialist and Precertification for services. This helps to ensure that You receive care that is Medically Necessary, provided in the right setting, and is a Covered Service.

In-Network Services

If Your care is rendered by a Primary Care Physician (PCP), Specialty Care Physician (SCP), or another In-Network Provider, benefits will be paid at the In-Network level. Regardless of Medical Necessity, no benefits will be paid for care that is not a Covered Service even if performed by a PCP, SCP, or another In-Network Provider. All medical care must be under the direction of doctors. We have final authority to determine the Medical Necessity of the service.

We may inform You that it is not Medically Necessary for You to receive services or remain in a Hospital or other Facility. This decision is made upon review of Your condition and treatment. You have the right to file a grievance as outlined in the "Appeals and Complaints" section of this Certificate.

- In-Network Providers - include PCPs, SCPs, other professional Providers, Hospitals, and other Facility Providers who contract with Us to perform services for You. PCPs include general practitioners, internists, family practitioners, pediatricians, geriatricians or other In-Network Providers as allowed by Us. The PCP is the doctor who may provide, coordinate, and arrange Your healthcare services. SCPs are In-Network doctors who provide specialty medical services not normally provided by a PCP.

For services rendered by In-Network Providers:

- You will not be required to file any claims for services You obtain directly from In-Network Providers. In-Network Providers will seek compensation for Covered Services rendered from Us and not from You except for approved Deductibles, Coinsurance, and/or Copayments. You may be billed by Your In-Network Provider(s) for any non-Covered Services You receive or when You have not acted in accordance with this Certificate.
- When required, prior approval of benefits is the responsibility of the In-Network Provider. See the "Requesting Approval for Benefits" section.

If there is no In-Network Provider who is qualified to perform the treatment You require, contact Us prior to receiving the service or treatment, and We may approve an Out-of-Network Provider for that service as an Authorized Service.

If You receive Covered Services from an Out-of-Network Provider after We failed to provide You with accurate information in Our Provider directory, or after We failed to respond to Your telephone or

web-based inquiry within the time required by federal law, Covered Services will be covered at the In-Network level.

Out-of-Network Services

Covered Services which are not obtained from a PCP, SCP or another In-Network Provider, or that are not an Authorized Service will be considered an Out-of-Network service and not covered under Your Plan. The only exceptions are Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center.

HMO Colorado has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from non-participating or Out-of-Network Providers could be balance billed by the non-participating/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.

We pay the benefits of this Certificate 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 several ways You can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See Your Plan's directory of In-Network Providers at www.anthem.com, which lists the doctors, Providers, and Facilities that participate in this Plan's network.
- Search for a Provider in Our mobile app, website, or HMO Colorado-enabled devices. Details on how to download the app can be found on Our website, www.anthem.com.
- Contact Member Services to ask for a list of doctors and Providers that participate in this Plan's network based on specialty and geographic area.
- Check with Your doctor or Provider.

If You need details about a Provider's license or training, or help choosing a doctor who is right for You, call the Member Services 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.

Primary Care Physician (In-Network Providers)

A key feature of this Plan is that one doctor will be mainly responsible for delivering and coordinating all of Your care. That doctor is called a Primary Care Physician (PCP). PCPs are usually internal medicine doctors, family practice doctors, general practitioners or pediatricians. As Your first point of contact, the PCP gives a wide range of healthcare services, including initial diagnosis and treatment, health supervision, management of chronic conditions, and preventive care.
You can get care for In-Network Providers without having to ask for written permission (called a Referral). Also, no authorization or Referral is needed for an OB/GYN and certified nurse midwife care. Your PCP can give You Referrals and information about Specialists who are In-Network.

Selecting a Primary Care Physician (PCP)

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

You have direct access for Medical Chats and Virtual Visits with Our online partners through Our mobile app.

PCPs include family practitioner, pediatrician, internist, qualified certified nurse practitioners or other qualified Primary Care Physicians, as required by law, for services within the scope of their license. For example, an internist or general practitioner may be chosen for adults and a pediatrician may be selected for children. If You want to change Your PCP, contact Us or refer to Our website, www.anthem.com.

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

Your PCP's job is to help You stay healthy, not just treat You when You are sick. After You choose a PCP, make an appointment with Your PCP. During this appointment, get to know Your PCP and help Your PCP get to know You. At Your first appointment, talk to Your PCP about:

- Personal health history.
- Family health history.
- Lifestyle.
- Any health concerns You have.

It is important to note, if You have not established a relationship with Your PCP, they may not be able to effectively treat You. To see a doctor, call their office:

- Tell them You are an HMO Colorado Member,
- Have Your Member Identification Card handy. The doctor's office may ask You for Your 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.

Connect with Us Using Our Mobile App

As soon as You enroll in this Plan, You should download Our mobile app. You can find details on how to do this on Our website, www.anthem.com.
Our goal is to make it easy for You to find answers to Your questions. You can chat with Us live in the app, or contact Us on Our website, www.anthem.com, or through an HMO Colorado-enabled device.

Dental Providers

You must select an In-Network dentist to receive dental benefits. Please call Our Member Services department at 1-800-627-0004 for help in finding an In-Network dentist or visit Our website at www.anthem.com. Please refer to Your ID Card for the name of the dental program that In-Network Providers have agreed to service when You are choosing an In-Network dentist.

Continuity of Care

If Your In-Network Provider leaves Our network for any reason other than termination for cause, and You are in active treatment, You may be able to continue seeing that Provider for a limited period of time and still receive In-Network benefits. "Active treatment" includes:

1) An ongoing course of treatment for a life-threatening condition.
2) An ongoing course of treatment for a serious acute condition, (examples include chemotherapy, radiation therapy and post-operative visits).
3) The second or third trimester of pregnancy and through the postpartum period.
4) An ongoing course of treatment for a health condition for which the doctor or healthcare Provider attests that discontinuing care by the current doctor or Provider would worsen Your condition or interfere with anticipated outcomes. An "ongoing course of treatment" includes treatments for Mental Health and Substance Abuse disorders.

   In these cases, You may be able to continue seeing that Provider for up to 90 days. If treatment is not complete at the end of 90 days, You may, depending on the condition, be entitled to a longer period allowed by law. If You wish to continue seeing the same Provider, You or Your doctor should contact Member Services for details

Identification Card

When You receive care, You must show Your Identification Card. Only a Member who has paid the Premiums under this Certificate has the right to services or benefits under this Certificate. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Certificate, he/she is responsible for the actual cost of the services or benefits.

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 Your condition is an Emergency, You should be taken to the nearest appropriate medical Facility. In the event of an Emergency call 911.
- Your coverage includes benefits for services rendered by Providers other than In-Network Providers when the condition treated is an Emergency, as defined in this Certificate.

Relationship of Parties (HMO Colorado and In-Network Providers)

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

Your healthcare 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.

REQUESTING APPROVAL FOR BENEFITS

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

Reviewing Where Services Are Provided

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

Examples include, but are not limited to:

- A service may be denied on an Inpatient basis at a Hospital but may be approved if provided on an Outpatient basis in a Hospital setting.
- A service may be denied on an Outpatient basis in a Hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical center, or in a doctor's office.
- A service may be denied at a Skilled Nursing Facility but may be approved in a home setting.

Certain Services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. We may decide that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment is more cost effective, available and appropriate. As used here, "clinically equivalent" means treatments that for most Members, will give You similar results for a disease or condition.

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

If We issue a Precertification approval, the approval is valid for 180 days after the date of approval and continues for the duration of the approved number or dates of treatment. However, coverage for or payment of the service or treatment reviewed is not guaranteed even if We decide Your services are Medically Necessary. For benefits to be covered, Precertification may consider on the date You get service:

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 the same as was preauthorized;
4. The service or supply must be for the same condition and setting as was preauthorized; and
5. You must not have exceeded any applicable limits under Your Plan.

Types of Reviews

- **Pre-service Review** - A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
    - **Precertification** - A required 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 Urgent Care services; however, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible. For labor / childbirth admissions, Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96

hours require Precertification.

- **Continued Stay/Concurrent Review** - A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a Facility or course of treatment.

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any doctor with knowledge of Your medical condition, without such care or treatment, or if You have a physical or mental disability, would create an imminent and substantial limitation on Your existing ability to live independently.

Urgent reviews are conducted under a shorter timeframe than standard reviews.

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

Who is Responsible for Precertification

Typically, In-Network Providers know which services need Precertification and will get any Precertification when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and in Colorado are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending doctor ("requesting Provider") will get in touch with Us to ask for a Precertification. However, You may request a Precertification, or You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for Precertification and under what circumstances.
To get more information on what services need Precertification, You or Your representative may call Member Services or may review the Precertification requirements at www.anthem.com.

Provider Network Status	Responsibility to Get Precertification	Comments
In-Network	Provider	The Colorado Provider must get Precertification when required
Out-of-Network	Member	The Member has no benefit coverage for an Out-of-Network Provider unless: • The Member gets approval to use an Out-of-Network Provider before the service is given; or • The Member requires an Emergency Care admission (See note below.) The Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary.

BlueCard® Provider	Member **(Except for Inpatient admissions)**	The Member has no benefit coverage for a BlueCard® Provider unless: • The Member gets approval to use a BlueCard® Provider before the service is given; or • The Member requires an Emergency Care admission (see note below.) If these are true, then • The Member must get Precertification when required (call Member Services). • The Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and/or setting is found not to be Medically Necessary. • **BlueCard® Providers must obtain Precertification for all Inpatient admissions.**
NOTE: Precertification is not required to receive Emergency Care. For Emergency Care admissions, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible.		

How Decisions are Made

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

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

If You are not satisfied with Our decision under this section of Your benefits, please refer to the “Appeals and Complaints” section to see what rights may be available to You.

Decision and Notice Requirements

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

Type of Review	Timeframe Requirement for Decision and Notification
Pre-service/ Expedited	2 business days or 72 hours, whichever is less, from the receipt of request
Pre-service Non-Expedited	5 business days from the receipt of the request
Concurrent/Continued Stay Review Expedited when hospitalized at the time of the request and no previous authorization exists	2 business days or 72 hours, whichever is less, from the receipt of the request
Concurrent/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
Concurrent/Continued Stay Review Expedited when request is received less than 24 hours before the end of the previous authorization	The request for Pre-service Review may be rejected
Concurrent/Continued Stay Review Non-Expedited	5 business days from the receipt of the request
Post-service Review	30 calendar days from the receipt of the request

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

We will notify You and Your Provider of Our decision as required by State and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

It is important that You and Your Provider submit the request for review with enough time and information for Us to meet these timeframes. Additional information about Our filing timeframes and procedures is available at www.anthem.com. If You or Your Provider fails to submit a complete and timely request for review according to Our filing procedures, We may reject the request and instead conduct a Post-Service review after a claim is submitted.

Important Information

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

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

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

You may find out whether a Provider is taking part in certain programs by checking Your on-line Provider directory, on-line Precertification list, or contacting the Member Services number on the back of Your Identification Card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical Utilization Review 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.

Health Plan Individual Case Management

Our health plan case management programs (Case Management) help coordinate services for Members with healthcare 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 healthcare 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 Plan. We will make Our decisions case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and HMO Colorado. 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 the Covered Services available under this Certificate. Covered Services are subject to all the terms and conditions listed in this Certificate, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, exclusions and Medical Necessity requirements.

Please read the following sections of this Certificate for more information about the Covered Services described in this section:

- “Schedule of Benefits (Who Pays What)” - for amounts You need to pay and benefit limits
- “How to Access Your Services and Obtain Approval of Benefits” - for details on selecting Providers and services that require Precertification
- “Limitations/Exclusions (What is Not Covered)” - for details on services that are not covered

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

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

Medical Services

Ambulance Services (Air, Ground and Water)

Medically Necessary ambulance services are covered when:

- You are transported by a State licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation;
- And one or more of the following are met:

  You are taken:

  1) From Your home, scene of an 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 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 an injury by medical professionals during 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 except for Surprise Billing Claims.

Ground Ambulance

Services are subject to Medical Necessity review by Us.

All scheduled ground ambulance services for nonemergency 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. We retain the right to select the air ambulance Provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for nonemergency 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 types 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). See the "Schedule of Benefits (Who Pays What)" for age limitations associated with Applied Behavior Analysis. 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 included in the Autism Treatment Plan:

- 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 Certificate;
- 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, to the extent permitted by law.

Clinical Trials

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review. The peer review requirement shall not be applicable to cancer clinical trials provided by i-iii below.
      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 (FDA);
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.

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

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 Certificate, 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 Certificate.

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

Anesthesia is 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.

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 Services

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes,

including diabetes self-management education programs.

Diabetes self-management training is covered for an individual with insulin dependent diabetes, noninsulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a doctor or a podiatrist; and
- Provided by a healthcare professional who is licensed, registered, or certified under State law.

For the purposes of this benefit, a "healthcare professional" means the doctor or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all doctor prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances”. Screenings for gestational diabetes are covered under “Preventive Care Services”.

Diagnostic Services Outpatient

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
- QCT Bone Densitometry
- Diagnostic CT Colonography

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

Doctor (Physician) Visits

Covered Services include:

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

Virtual Visits and Telehealth Services

Covered Services include virtual Telemedicine/Telehealth visits that are appropriately provided through the internet via video or chat. This includes visits with Providers who also provide services in person, as well as online-only Providers.

- **Online Visits** Covered Services include a medical visit with the doctor using the internet by a webcam, chat or voice or other platform approved by Us. Online visits do not include reporting normal laboratory 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. Online visits are not the same as telehealth services and can, at times, include audio-only interactions but do not include store-and-forward transfers. For Mental Health and Substance Abuse Online Visits, see the "Mental Health and Substance Abuse Services" section.
- **Telehealth Services** Covered Services that are appropriately provided by a telehealth Provider in accordance with applicable legal requirements will be eligible for benefits under this Certificate. Telehealth means the mode of delivering health care or other health services through HIPAA-compliant systems, including information, electronic and communication technologies, remote monitoring technologies and store-and-forward transfers, to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health. In-person contact between a health care Provider and the patient is not required for these services. Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail, except where required by applicable law. If You have any questions about this coverage, or receive a bill please contact Member Services at the number on the back of Your Identification Card.

Please Note: Not all services can be delivered through virtual visits. Certain services require equipment and/or direct physical hands-on care that cannot be provided remotely. Also, please note that not all Providers offer virtual visits.

If You have any questions about this coverage, please contact Member Services at the number on the back of Your Identification Card.

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

Retail Health Clinic Care for limited basic healthcare services to Members on a "walk-in" basis. These clinics are normally found in major Pharmacies or retail stores. Healthcare services are typically given by physician 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.

Allergy Services for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

Specialist e-Consultations are electronic communications between Your PCP, who is rendering care to You, and an In-Network Specialist to help evaluate Your condition or diagnosis. The consultation will be at no cost to You. Your PCP may consider the information provided by the In-Network Specialist in determining Your treatment. The consultation will be conducted using electronic information and communication technologies and the results may be documented in an electronic health record.

Emergency Care Services

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

Benefits are available in a Facility for services and supplies to treat the onset of symptoms for an

Emergency, which is defined below.

When You receive Emergency Services (except ambulance services) from an Out-of-Network Provider at a Facility within Colorado, You will not be responsible for amounts in excess of the Maximum Allowed Amount.

Emergency (Emergency Medical Condition)

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

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

Stabilize, with respect to an Emergency Medical Condition, 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 individual 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.

Medically Necessary services will be covered whether You get care from an In-Network or Out-of-Network Provider. Emergency Care You get from an Out-of-Network Provider will be covered as an In-Network service and will not require Precertification. You will not have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount but You will still be responsible for any applicable Coinsurance, Copayment or Deductible.

The Maximum Allowed Amount for Emergency Care from an Out-of-Network Provider will be determined using the median Plan In-Network contract rate We pay In-Network Providers for the geographic area where the service is provided.

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. If You or Your doctor does not call Us, You may have to pay for services that are determined to be not Medically Necessary.

Treatment You get after Your condition has stabilized is not Emergency Care. If You continue to get care from an Out-of-Network Provider, Covered Services will not be available unless We agree to cover them as an Authorized Service.

Habilitative Services

Habilitative Services are healthcare services and devices that help You keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not 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 Care Services

Benefits are available for Covered Services performed by a Home Healthcare Agency or other Provider in Your home. To be eligible for benefits, You must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an Outpatient basis. Services must be prescribed by a doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include, but are not limited to:

- Visits by a licensed healthcare professional, including nursing services by an R.N. or L.P.N, a therapist, or home health aide.
- Infusion therapy; refer to “Therapy Services Outpatient,” later in this section for more information.
- Medical / social services.
- Diagnostic services.
- Nutritional guidance.
- Training of the patient and/or family/caregiver.
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the home healthcare Provider. Other organizations may give services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the home healthcare Provider.
- Medical supplies.
- Durable Medical Equipment.
- Therapy services (except for chiropractic care / manipulation therapy which will not be covered when given in the home).
- Private duty nursing in the home.

Hospice Care

Hospice care is a coordinated plan of home, Inpatient and/or Outpatient care that provides palliative, supportive medical, psychological, psychosocial, and other health services to terminally ill patients.

Covered Services and supplies are those 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.

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 by HMO Colorado considering any information provided by the attending doctor or the hospice Facility. HMO Colorado reserves the right to review treatment plans.

- 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.
- Skilled nursing services and home health 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.
- 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.
- Nutritional counseling by a nutritionist or dietitian.
- Inpatient respite care may be limited to a maximum of five consecutive days per admission
- 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 doctor and the hospice medical director must certify that You are terminally ill and have approximately 12 months to live, and (2) Your doctor must consent to Your care by the hospice and must be consulted in the development of Your treatment plan. You may access hospice care while also participating in a clinical trial or continuing disease modifying therapy, as ordered by Your treating Provider. Disease modifying therapy treats the underlying terminal illness. The hospice must maintain a written treatment plan on file and furnish to Us upon request.

Covered Services beyond those listed above as ordered by Your treating Provider, may be available while in hospice and are detailed in other sections of this Certificate.

Hospital Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting. Benefits for room, board, nursing and ancillary services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that You use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.
- Operating, childbirth, and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

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

Outpatient Hospital Care

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding ambulatory surgical center,
- Mental Health and Substance Abuse Facility,
- 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,
- 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.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Maternity services incurred prior to Your Effective Date are not covered.

Covered maternity services include:

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

If You are pregnant on Your Effective Date and in the first trimester of the pregnancy, You must change to an In-Network Provider to have Covered Services covered at the In-Network level. If You are pregnant on Your Effective Date and in Your second or third trimester of pregnancy (13 weeks or

later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if You fill out a Continuation of Care Request Form and send it to Us. Covered Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period. Please see "Continuity of Care" in the "How To Access Your Services And Obtain Approval Of Benefits" section regarding a request to continue to see the same Provider for services.

Note: Under federal law, We may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). If the 48 hours following a vaginal delivery or 96 hours after a cesarean section falls after 8 p.m., coverage shall continue until 8 a.m. the following morning. However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with and with the agreement of the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, We may not require a Provider to get Precertification from Us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Contraceptive Benefits

Benefits include oral contraceptive drugs, injectable contraceptive drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that section for further details.

Sterilization Services

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

Abortion Services

Benefits for abortions in the case of rape or incest, or for a pregnancy which, as certified by a doctor, places the woman in danger of death unless an abortion is performed (i.e., abortions for which federal funding is allowed).

Infertility Services

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause involuntary infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency), when received from an In-Network Provider. Covered Services also include artificial insemination that satisfies Our medical policy. Donor eggs, donor semen or services related to their procurement or storage are not Covered Services. Prescription Drugs related to infertility are not Covered Services, except where specifically required by law.

Precertification must be obtained for all covered infertility services.

Medical Supplies, Durable Medical Equipment and Appliances

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, purchase or rent-to-purchase equipment and

devices, and continuous rental equipment and 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, except when damage is due to neglect. Benefits also include supplies and equipment needed for the use of the equipment or device.

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 Certificate, benefits are available for the following hearing aids, including bone-anchored hearing aids, and related services, 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 Outpatient" 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 five Years, a new hearing aid will be a Covered Service when alterations to Your existing hearing aid cannot adequately meet Your needs or be repaired; and
- Visits for fitting, counseling, adjustments and repairs after receiving the covered hearing aid.

Orthotics and Special Footwear

When Medically Necessary, benefits are available for:

- Certain types of orthotics (braces, boots, splints) for foot disfigurements resulting from bone deformity, motor impairment, paralysis, or amputation. This includes, but is not limited to, disfigurement caused by cerebral palsy, arthritis, polio, spina bifida, diabetes, accident, injury, or developmental disability, and
- Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent or treat diabetes-related complications.

Covered Services must be ordered by a doctor and 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 Necessary.

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

- Artificial limbs and accessories;
- 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 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, 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.

Diabetic Equipment and Supplies

Your Plan includes coverage for diabetic equipment and supplies (insulin pump, glucose monitor including continuous glucose monitors, lancets and test strips, etc.)

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.

Medical Foods

Benefits are given for medical foods for home use for metabolic disorders which may be taken by mouth or enterally. A Provider must have prescribed the medical foods that are designed and manufactured for inherited enzymatic disorders involved in the metabolism of amino, organic, and fatty acids, as well as severe protein allergic conditions. Disorders include those as required by law, including, but not limited to:

- Phenylketonuria;
- Maternal phenylketonuria;
- Maple syrup urine disease;
- Tyrosinemia;
- Homocystinuria;
- Histidinemia;
- Urea cycle disorders;
- Hyperlysinemia;
- Glutaric acidemias;
- Methylmalonic acidemia; and
- Propionic acidemia.
- Immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins;
- Severe food protein induced enterocolitis syndrome;
- Eosinophlic disorders as evidenced by the results of a biopsy; and
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.

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

Mental Health and Substance Abuse Services

Benefits are available for the diagnosis, crisis intervention and treatment of acute Mental Disorders and Substance Abuse conditions. 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. For the purposes of this section the Commission on

Accreditation of Rehabilitation Facilities is abbreviated as CARF.

Covered Services include the following:

- Inpatient services in a Joint Commission accredited Hospital or any Facility that We must cover per State law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- Outpatient Services including in-home and office visits and treatment in an Outpatient department of a Hospital or Joint Commission or CARF-accredited Outpatient Facility, such as Partial Hospitalization Programs and Intensive Outpatient Programs.
- Online Visits. Covered Services include a medical visit with the doctor using the internet by a webcam, chat or voice or other platform approved by Us. Online visits do not include reporting normal laboratory 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. Online visits are not the same as Telehealth Services and can, at times, include audio-only interactions but do not include store-and-forward transfers.
- Residential treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center accredited by The Joint Commission or CARF. It offers individualized and intensive treatment and includes:
    - Observation and assessment by a psychiatrist weekly or more often,
    - Rehabilitation and therapy.

Note: No Member will be denied coverage for medical, surgical, behavioral, mental, or substance abuse services as a result of self-harm or suicide attempt or completion.

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 Provider licensed by the State to give these services, when We have to cover them by law.

Physical Medicine and Rehabilitation Services

Physical medicine and Rehabilitation Services are a structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Preventive Care Services

Preventive care services include screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable State law. This means many preventive care services are covered with no Deductible,

Copayments or Coinsurance when You use an In-Network Provider.

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

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
   - Breast cancer,
   - Cervical cancer,
   - High blood pressure,
   - Type 2 Diabetes Mellitus,
   - Cholesterol,
   - Child or adult obesity,
   - Colorectal cancer.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. At least one mental health wellness exam every Benefit Period, to the extent required by applicable law;
4. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration;
5. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
   - Contraceptive coverage includes Generic oral contraceptives as well as other contraceptive medications such as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Brand Drugs will be covered, as preventive care benefits when Medically Necessary, otherwise they will be covered under the "Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy".

     The 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 for the durations or supply minimums required by applicable law.

     A Prescription contraceptive provided by an In-Network Pharmacy can be dispensed to a Member in a three-month supply for the first dispensing. It can be dispensed for a 12-month supply for subsequent dispensings of the same prescription contraceptive or through the end of the Member's coverage under this policy. In case of vaginal contraceptive rings, it can be dispensed intended to last for three months.
   - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one per Calendar Year or as required by law.
   - Gestational diabetes screening.
6. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
   - Counseling.
   - Prescription Drugs obtained at a Retail or Home Delivery Pharmacy.
   - Nicotine replacement therapy products obtained at a Retail or Home Delivery Pharmacy when prescribed by a Provider, including over-the-counter (OTC) nicotine gum, lozenges and patches.
   - Prescription Drugs and OTC items are limited to a no more than 180 day supply per 365 days.

7. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
    - Aspirin
    - Folic acid supplement
    - Bowel preparations
    - At least one PrEP Prescription Drug

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

You may call Member Services at the number on Your Identification Card for more details about these services or view the federal government's websites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits
- http://www.ahrq.gov
- http://www.cdc.gov/vaccines/acip/index.html

Cancer Screenings

At HMO Colorado 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, to the extent required by applicable law. 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, sigmoidoscopies 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.

Coverage is also available for colorectal cancer screening at no cost to Members, when received by an In-Network Provider, when a Member is at high risk for colorectal cancer or has had prior occurrence of cancer or precursor neoplastic polyps, prior occurrence of a chronic digestive disease condition or other predisposing factors.

Rehabilitative Services

Rehabilitative Services are healthcare services that help You keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.

These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings.

Skilled Nursing 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 Facility. Custodial care is not a Covered Service.

Surgery

Your Plan covers surgical services on an Inpatient or Outpatient basis, including surgeries performed in a doctor's office or an ambulatory surgical center. 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.

Oral Surgery

Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered.

Benefits are limited to certain oral surgeries including:

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

Reconstructive Surgery

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

Note: This section does not apply to orthognathic surgery.

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.

Bariatric / Weight Loss Surgery

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

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth (braces), repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services Outpatient

Physical Medicine Therapy Services

For children under age six, 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 does not matter if the reason for the therapy is to maintain (not improve) the child's skills.

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

Covered Services include:

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

acupuncture treatment will be included in the payment for the visit and will not be reimbursed in addition to the visit. Coverage will be provided only to the extent required by law.

Early Intervention Services

From the Member's birth until the Member's third birthday, this Certificate 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: nonemergency 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 Certificate for congenital defects or birth abnormalities.

Other Therapy Services

Benefits are also available for:

- **Cardiac Rehabilitation** - Medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** - Treatment of an illness by chemical or biological antineoplastic agents. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** - Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an Outpatient dialysis Facility or doctor's office. Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis.
- **Infusion Therapy** - Nursing, Durable Medical Equipment and drug services that are delivered and administered to You through an I.V. Also includes Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). 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. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** - Includes Outpatient short-term respiratory care to restore Your health after an illness or injury.
- **Radiation Therapy** - Treatment of an illness by X-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration and treatment planning.
- **Respiratory/Inhalation 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 Certificate provides benefits for many of the charges for transgender surgery (also known as sex reassignment surgery) and hormone therapies as part of the treatment of gender dysphoria or gender identity disorder. Benefits must be approved by Us for the type of transgender surgery requested and must be authorized prior to being performed. Charges for services that are not authorized for the transgender surgery requested, will not be considered Covered Services. Some conditions and age restrictions apply, and all services must be authorized by Us.

Covered Services, when approved as meeting Our criteria as Medically Necessary, may include, but are not limited to:

- Feminizing vaginoplasty,
- Masculinizing phalloplasty / scrotoplasty,
- Reduction thyrochondroplasty,
- Augmentation mammoplasty,
- Facial feminization procedures,
- Feminizing hormone therapy,
- Masculinizing hormone therapy,
- Puberty-suppressant,
- Blepharoplasty (eye and lid modification),
- Face/forehead and/or neck tightening,
- Facial bone remodeling for facial feminization,
- Genioplasty (chin width reduction),
- Rhytidectomy (cheek, chin, and neck),
- Cheek, chin, and nose implants,
- Lip lift/augmentation,
- Mandibular angle augmentation/creation/reduction (jaw),
- Orbital re-contouring,
- Rhinoplasty (nose reshaping),
- Laser or electrolysis hair removal,
- Breast/chest augmentation, reeducation, construction, if appropriate based on age of the Member.

Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood

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 Certificate.

Covered Transplant Procedure

A covered transplant procedure is any Medically Necessary human organ and bone marrow/stem cell/cord blood 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.

The initial evaluation, any added tests to determine Your eligibility as a candidate for a transplant by Your Provider, and the collection and storage of bone marrow/stem cells are included in the covered transplant procedure benefit regardless of the date of service.

Unrelated Donor Searches

Your Plan includes Human Leukocyte Antigen (HLA) testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens, for use in bone marrow transplantation per transplant. The testing must be done at an accredited Facility.

When approved by Us, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell/cord blood transplants performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants for a covered transplant procedure. Except for live organ transplants, donor search charges are limited to the 10 best matched donors per transplant, identified by an authorized registry.

Live Donor Health Services

Medically Necessary charges for the procurement, performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants, of an organ from a live donor are covered up to the Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement. A live donor is a person who provides the organ, part of an organ, or tissue for transplantation while alive to another person.

Transplant Benefit Period

The transplant benefit period starts one day prior to a covered transplant solid organ procedure and one day prior to high dose chemotherapy or preparative regimen for bone marrow stem cell transplants 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, to the extent covered, start on the day of the covered transplant procedure and continue to the date of discharge.

Preauthorization and Precertification

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

Precertification is required before We will cover benefits for a transplant. Your doctor must certify, and We must agree, that the transplant is Medically Necessary. Your doctor should send a written request for Precertification to Us as soon as possible to start this process. Please see the “Requesting Approval for Benefits” section for how to obtain Precertification.

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. Our assistance with travel expenses includes transportation to and from the Facility and lodging for the patient and one companion. Travel costs for the donor are generally not covered, unless We make an exception and approve them in advance of the procedure. 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.

The human organ and bone marrow/stem cell/cord blood transplant 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 is included in the covered transplant procedure benefit regardless of the date of service.

The above services are covered as Inpatient services, Outpatient services or doctor home visits and office services depending where the service is performed and are subject to Member Cost Shares.

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 may include:

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

Prescription Drugs

This section describes how You can obtain covered Prescription Drugs administered by a medical Provider or through a Retail Pharmacy, Our Home Delivery Pharmacy, or Our Specialty Pharmacy. Please see the information below that describes how Prescription Drugs are covered.

Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs, that must be administered to You as part of a doctor's visit, home care visit, or at an Outpatient Facility and are Covered Services. This may include drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any drug that must be administered by a Provider. This section applies when a Provider orders the drug and a medical Provider administers it to You in a medical setting. Benefits for drugs that You inject or get through Your Pharmacy benefit (i.e., Self-Administered Drugs) are not covered under this section. Benefits for those drugs are described in the "Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy" section.

Important Details About Prescription Drug Coverage

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, Your prescribing doctor may be asked to give more details before We can decide if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, We have established criteria.

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

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

You will not need to undergo step therapy, as required under applicable State law, for HIV infection prevention and stage four metastatic cancer Prescription Drugs.

Precertification

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

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

We will review requests for Precertification of Prescription Drugs according to the same timeframes listed below in the "Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy" section.

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

If Precertification is denied, You have the right to file a grievance as outlined in the “Appeals and Complaints” section of this Certificate.

Designated Pharmacy Provider

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

For Prescription Drugs that are shipped to You or Your Provider and administered in Your Provider’s office, You and Your Provider are required to order from a Designated Pharmacy Provider. A patient care coordinator will work with You and Your Provider to obtain Precertification and to assist shipment to Your Provider’s office.

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

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

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

Therapeutic Substitution

Therapeutic substitution is an optional program that tells You and Your doctor about alternatives to certain prescribed drugs. We may contact You and Your doctor to make You aware of these choices. Only You and Your doctor can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic drug substitutes, call Pharmacy Member Services at the phone number on the back of Your Identification Card.

Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy

Your Plan also includes benefits for Prescription Drugs You get at a Retail, Home Delivery, or Specialty Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery 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.

Certain contracted Retail Pharmacies can fill Your Prescription at the same Cost Shares that apply to the Home Delivery Pharmacy level of benefits. Please ask Your Pharmacy if they offer this special arrangement or call Pharmacy Member Services at the phone number on Your ID Card for a list of Retail Pharmacies that offer the Home Delivery Pharmacy level of benefits.

Note: Benefits for Prescription Drugs, including Specialty Drugs, which are administered to You by a medical Provider in a medical setting (e.g., doctor’s office visit, home care visit, or Outpatient Facility) are covered under the “Prescription Drugs Administered by a Medical Provider” benefit. Please read that section for important details.

Prescription Drug Benefits

Prescription Drug benefits may require Precertification to determine if Your drugs should be covered. Your In-Network pharmacist will be told if Precertification is required and if any additional details are needed for Us to decide benefits.

Precertification

Prescribing Providers must obtain Precertification for drug edits in order for You to get benefits for certain drugs. At times, Your Provider will initiate a Precertification on Your behalf before Your Pharmacy fills Your Prescription. At other times, the Pharmacy may make You or Your Provider aware that a Precertification or other information is needed. In order to determine if the Prescription Drug is eligible for coverage, We have established criteria.

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

- Quantity, dose, and frequency of administration;
- Specific clinical criteria (including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease);
- Specific Provider qualifications (including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies));
- Step therapy requiring one drug, drug regimen or treatment be used, where permitted by law, prior to use of another drug, drug regimen or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated;
- Use of a Prescription Drug List (as described below).

You will not need to undergo step therapy, as required under applicable State law, for HIV infection prevention and stage four metastatic cancer Prescription Drugs.

Where required by applicable law, We will cover the initial five day supply (within a 12 month period) of at least one FDA approved drug, prescribed by Your doctor and on Our Prescription Drug List, which is used for the treatment of opioid dependency. At least one such Prescription Drug will not require Precertification for the initial five day supply. But requests of greater supplies, refills, or for drugs beyond those We have approved may be subject to Precertification requirements or otherwise not eligible for coverage. For more information on the Prescription Drug List and which Prescription Drugs require Precertification, please call the phone number on the back of Your Identification Card or visit Our website at www.anthem.com.

You or Your Provider can get the list of the drugs that require Precertification by calling Pharmacy Member Services at the phone number on the back of Your Identification Card or check Our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with Us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

We may, from time to time, waive, enhance, change or end certain Precertification and/or alternate benefits, if in Our sole discretion; such change furthers the provision of cost effective, value based and/or quality services.

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

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

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

- If all needed information is provided with the request, We approve or deny it within two business days of receiving the request;
- If We need more information to make a decision, We will tell the prescribing Provider what

information is needed within two business days of receiving the request. If the information is timely provided, We will make a decision within the timeframes provided by law;
- If the prescribing Provider does not supply the requested information within two business days of receiving Our request, the request will be deemed denied.

Note: If We do not request additional information or provide notification of approval or denial as required by applicable law, the request will be deemed approved. We will give notice of Our decision as required by State and federal law.

Please refer to the section "How to Access Your Services and Obtain Approval of Benefits" under "Requesting Approval for Benefits" for more details.

If Precertification is denied, You have the right to file a grievance as outlined in the "Appeals and Complaints" section of this Certificate.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the 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. Controlled substances must be prescribed by a licensed Provider with an active Drug Enforcement Administration (DEA) license.

Benefits are available for the following:

- Prescription 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. A Prescription contraceptive provided by an In-Network Pharmacy can be dispensed to a Member in a three-month supply for the first dispensing. It can be dispensed for a 12-month supply for subsequent dispensings of the same prescription contraceptive or through the end of the Member's coverage under this policy. In case of vaginal contraceptive rings, it can be dispensed intended to last for three months.
- Flu shots (including administration).

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 Certificate.

Where You Can Get Prescription Drugs

In-Network Pharmacy

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. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when You get the drug. If You do not have Your Identification Card, the Pharmacy will charge You the full retail price of the Prescription and will 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.

Note: If We determine that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of In-Network Pharmacies may be limited. If this happens, We may require You to select a single In-Network Pharmacy that will provide and coordinate all future Pharmacy services. Benefits will only be paid if You use the single In-Network Pharmacy. We will contact You if We determine that use of a single In-Network Pharmacy is needed and give You options as to which In-Network Pharmacy You may use. If You do not select one of the In-Network Pharmacies We offer within 31 days, We will select a single In-Network Pharmacy for You. If You disagree with Our decision, You may ask Us to reconsider it as outlined in the "Appeals and Complaints" section of this Certificate.

In addition, if We determine that You may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Providers for Controlled Substance Prescriptions may be limited. If this happens, We may require You to select a single In-Network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if You use the single In-Network Provider. We will contact You if We determine that use of a single In-Network Provider is needed and give You options as to which In-Network Provider You may use. If You do not select one of the In-Network Providers We offer within 31 days, We will select a single In-Network Provider for You. If You disagree with Our decision, You may ask Us to reconsider it as outlined in the "Appeals and Complaints" section of this Certificate.

Your Plan has two levels of coverage. To get the lowest out-of-pocket cost, You must get Covered Services from a Level 1 In-Network Pharmacy. If You get Covered Services from any other In-Network Pharmacy, benefits will be covered at Level 2 and You may pay more in Deductible, Copayments, and Coinsurance.

Level 1 In-Network Pharmacies. When You go to Level 1 In-Network Pharmacies, (also referred to as Core Pharmacies), You pay a lower Copayment / Coinsurance on Covered Services than when You go to other In-Network Providers.
Level 2 In-Network Pharmacies. When You go to Level 2 In-Network Pharmacies, (also referred to as Wrap Pharmacies), You pay a higher Copayment / Coinsurance on Covered Services than when You go to a Level 1 In-Network Pharmacy.

Specialty Pharmacy

We keep a list of Specialty Drugs that may be covered 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. We may require You or Your doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy.

When You use the PBM's Specialty Pharmacy its patient care coordinator will work with You and Your doctor to get Precertification and to ship Your Specialty Drugs to Your home or Your preferred address. Your patient care coordinator will also tell You when it is time to refill Your Prescription.

You can get the list of covered Specialty Drugs by calling Pharmacy Member Services at the phone number on the back of Your Identification Card or check Our website at www.anthem.com.

When You Order Your Prescription Through the PBM's Specialty Pharmacy

You can only have Your Prescription for a Specialty Drug filled through the PBM's Specialty Pharmacy. Specialty Drugs are limited to a 30-day supply per fill. The PBM's Specialty Pharmacy 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 HMO Colorado BCBS.

Specialty Pharmacy Program

If You are out of a Specialty Drug which must be obtained through the PBM's 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/Coinsurance, if any.

If You order Your Specialty Drug through the PBM's Specialty Pharmacy and it does not arrive, if Your doctor 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 Member Services representative from the PBM's Specialty Pharmacy will coordinate the exception and You will not be required to pay additional Coinsurance.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets You get certain drugs by mail if You take them on a regular basis (Maintenance Medication). You will need to contact the PBM to sign up when You first use the service. You can mail written Prescriptions from Your doctor or have Your doctor send the Prescription to the Home Delivery Pharmacy. Your doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when You ask for a Prescription or refill.

Maintenance Medication

A 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 the Prescription Drug You are taking is a Maintenance Medication, please call Pharmacy Member Services at the number on the back of Your Identification Card or check Our website at www.anthem.com for more details.

When using home delivery, 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 home delivery program, You can call Pharmacy Member Services toll-free at 1-833-236-6196.

The Prescription must state the dosage and Your name and address; it must be signed by Your doctor.

The first home delivery 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 home delivery Prescriptions for that insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated home delivery Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the home delivery Prescription Drug program including, but not limited to, antibiotics, drugs not on the Prescription Drug List, drugs and medications to treat infertility, impotence and/or sexual dysfunction, injectables, including self-administered injectables except insulin. Please check with the home delivery Prescription Drug program Member Services department at 1-833-236-6196 for availability of the drug or medication.

What You Pay for Prescription Drugs

Tiers

Your share of the cost for Prescription Drugs may vary based on the tier the drug is in.

To get the lowest out-of-pocket cost, You must get Covered Services from a Level 1 In-Network Pharmacy.

- **Tier 1** Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred drugs that may be Generic, single source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.
  Certain low cost drugs, on Tier 1, may be available to Members at no Cost Share. These drugs are listed on Our Prescription Drug List (formulary).
- **Tier 2** Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.
- **Tier 3** Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may

contain higher cost, preferred, and non-preferred drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.

- **Tier 4** Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.

Prescription Drug List

We also have a Prescription Drug List (a formulary) which is a list of drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain drugs if they are not on the Prescription Drug List.

The Prescription 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 List, please refer to Our website at www.anthem.com.

We retain the right, at Our discretion, to decide coverage based upon medication dosages, dosage forms, manufacturer and administration methods (i.e., oral, injected, topical, or inhaled) and may cover one form instead of another as Medically Necessary.

This Plan limits Prescription Drug coverage to those Prescription Drugs listed on Our Prescription Drug List. This formulary contains a limited number of Prescription Drugs, and may be different than the formulary for other HMO Colorado BCBS products. Benefits may not be covered for certain Prescription Drugs if they are not on the Prescription Drug List. Generally, it includes select Generic Drug with limited Brand Drug coverage. This list is subject to periodic review and modification by HMO Colorado BCBS. We may add or delete Prescription Drugs from this Prescription Drug List from time to time. Inclusion of a drug or related item on the covered Prescription Drug List is not a guarantee of coverage. A description of the Prescription Drugs that are listed on this Prescription Drug List 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 Prescription Drug 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 Appeal, including the right to request independent external review, as explained in the “Appeals and Complaints” section of this Certificate.

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 and Complaints” section of this Certificate.

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 Plan. For additional information about the exception processes for drugs not included on Your Plan’s Prescription Drug List, please call the Pharmacy Member Services telephone number on the back of Your Identification Card.

Drug Utilization Review

If there are patterns of over utilization or misuse of drugs, We will notify Your personal doctor and Your pharmacist. We reserve the right to limit benefits to prevent over utilization of drugs.

Additional Features of Your Prescription Drug Pharmacy Benefit

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Benefits (Who Pays What)." In most cases, You must use a certain amount of Your Prescription before it can be refilled. In some cases We may let You get an early refill. For example, We may let You refill Your Prescription early if it is decided that You need a larger dose. Early refills may also be available for Prescription eye drops. In addition, one additional bottle may be available for Prescription eye drops, if the bottle is requested at the time of the original Prescription is filled, and is needed for use by a day care center or school. Prescription eye drop means a liquid Prescription Drug which is applied directly to the eye from a bottle or by means of a dropper, or as defined by Colorado law. We will work with the Pharmacy to decide when this should happen.

If You are going on vacation and You need more than the day supply allowed, You should ask Your pharmacist to call Our PBM and ask for an override for one early refill. If You need more than one early refill, please call Pharmacy Member Services at the number on the back of Your Identification Card.

Therapeutic Substitution

Therapeutic substitution is an optional program that tells You and Your doctor about alternatives to certain prescribed drugs. We may contact You and Your doctor to make You aware of these choices. Only You and Your doctor can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic drug substitutes, call Pharmacy Member Services at the phone 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. 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 Pharmacy Member Services number on Your Member Identification Card or log on to the Member website at www.anthem.com.

Drug Cost Share Assistance Programs

Where permitted by applicable law, if You participate in certain drug Cost Share assistance programs offered by drug manufacturers or other third parties to reduce the Cost Share (Copayment, Coinsurance) You pay for certain Specialty Drugs, the reduced amount You pay may be the amount We apply to Your Deductible and/or Out-of-Pocket Maximum . Your eligibility to participate in such programs is dependent on the programs' applicable terms and conditions, which may be subject to change from time to time. We may discontinue applying such reduced amounts to Your Cost Share at any given time.

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 Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Prescription Drug List.

Rebate Impact on Prescription Drugs You Get at Retail or Home Delivery Pharmacies

HMO Colorado and/or its PBM may also, from time to time, enter into agreements that result in HMO Colorado receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug

manufacturers, Prescription Drug distributors or others.

You will be able to take advantage of a portion of the cost savings anticipated by HMO Colorado from rebates on Prescription Drugs purchased by You from Retail, Home Delivery, or Specialty Pharmacies under this section. If the Prescription Drug purchased by You is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the Maximum Allowed Amount for the Prescription Drug. Any Deductible or Coinsurance would be calculated using that reduced amount. The remaining value of that rebate will be used to reduce the cost of coverage for all Members enrolled in coverage of this type.

It is important to note that not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the ultimate rebate will not be known at the time You purchase the Prescription Drug, the amount the rebate applied to Your claim will be based on an estimate. Payment on Your claim will not be adjusted if the later determined rebate value is higher or lower than Our original estimate.

Pediatric Dental Care

Your Dental Benefits. Dental care treatment decisions are made by You and Your dentist. We cover treatment based on what benefits You have, not whether the care is medically or dentally necessary. The only exception is when You get orthodontic care -- We do review those services to make sure they are appropriate.

Pretreatment Estimates. When You need major dental care, like crowns, root canals, dentures/bridges, oral surgery, or braces -- it is best to go over a care or treatment plan with Your dentist beforehand. It should include a "pretreatment estimate" so You know what it will cost.

You or Your dentist can send Us the pretreatment estimate to get an idea of how much of the cost Your benefits will cover. Then You can work with Your dentist to make financial arrangements, before You start treatment.

Pediatric Dental Essential Health Benefits. The following dental care services are covered for Members until the end of the month in which they turn 19. All Covered Services are subject to the terms, limitations, and exclusions of this Certificate. See the "Schedule of Benefits (Who Pays What)" for any applicable Deductible, Coinsurance, Copayment, and benefit limitation information.

Diagnostic and Preventive Services

Oral Exams. Two oral exams are covered every 12 months.

Radiographs (x-rays)

- Full mouth X-rays (also called complete series) - one time per 60 months, includes bitewings.
- Periapical(s)
- Bitewings - one series per 12 month period, but not covered in the same period as full mouth or panoramic X-rays.
- Panoramic film - one time per 60 months.

Dental Cleaning (prophylaxis) . Procedure to remove plaque, tartar (calculus), and stain from teeth. Covered one time per 12 months.

Fluoride Treatment (topical application or fluoride varnish). Covered two times per 12 month period.

Sealants. Covered once per tooth per 36 months. Covered only when given on permanent molar teeth with occlusal surfaces intact, no caries (decay) exists, and 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 Treatment (also called palliative treatment). Covered for the temporary relief of pain or infection.

Basic Restorative Services

Fillings (restorations). Covered one time per tooth surface in a 24 month period. Fillings are covered when placed on primary or permanent teeth. There are two kinds of fillings covered under this Plan:

- Amalgam. These are silver fillings that are used to restore decayed or fractured posterior (back) teeth.
- Composite Resin. These are tooth-colored fillings that are used to restore decayed or fractured anterior (front) teeth. If You choose to have a composite resin filling placed on a back tooth,

We will pay up to the Maximum Allowed Amount for an amalgam filling. You will be responsible to pay for the difference, if the dentist charges more, plus any applicable Deductible or Coinsurance.

Endodontic Services

Endodontic Therapy

- Therapeutic pulpotomy. Covered on primary teeth.
- Root canal therapy. Covered on permanent teeth.

Oral Surgery Services

Basic Extractions

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

Complex Surgical Extractions. Surgical removal of third molars is covered only when symptoms of oral pathology exists. The benefit for complex surgical extractions includes intravenous conscious sedation, IV sedation or general anesthesia.

- Surgical removal of erupted tooth.
- Surgical removal of impacted tooth.
- Surgical removal of residual tooth roots.

Major Restorative Services

Gold foil restorations. Gold foil restorations are covered at the same frequency as an amalgam filling. Gold foil restorations will be paid up to the same Maximum Allowed Amount for an amalgam filling. You are responsible to pay for any amount over the Maximum Allowed Amount, plus any applicable Deductible and Coinsurance.

Inlays. Inlays are covered at the same frequency as an amalgam filling. Inlays will be paid up to the same Maximum Allowed Amount for an amalgam filling. You are responsible to pay for any amount over the Maximum Allowed Amount, plus any applicable Deductible and Coinsurance.

Prefabricated Stainless Steel or Resin Crown. Covered once per tooth in 24 months.

Recement Crown

Sedative Filling

Pin Retention. Per tooth, in addition to restoration.

Orthodontic Care

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies, including conditions such as cleft lip and cleft palate. Talk to Your dental Provider about getting a pretreatment estimate for Your orthodontic treatment plan, so You have an idea upfront what the treatment and costs will be. You or Your dental Provider should send it to Us so We can help You understand how much is covered by Your benefits.

Dentally Necessary Orthodontic Care. This Plan will only cover orthodontic care that is dentally necessary -- at least one of these criteria must be present:

- Spacing between adjacent teeth that interferes with Your biting function
- Overbite that causes the lower front (anterior) teeth to impinge on the roof of Your mouth when You bite
- The position of Your jaw or teeth impairs Your ability to bite or chew

- On an objective, professional orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care

What Orthodontic Care Includes. Orthodontic care may include the following types of treatment:

- Limited Treatment. A treatment usually given for minor tooth movement and is not a full treatment case.
- Interceptive Treatment (also known as phase I treatment). This is a limited treatment that is used to prevent or lessen the need for more involved treatment in the future.
- Comprehensive or Complete Treatment. A full kind of treatment that includes all radiographs, diagnostic casts and models, orthodontic appliances and office visits.
- Removable Appliance Therapy. Treatment that uses an appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy. Treatment that uses an appliance that is cemented or bonded to the teeth.
- Complex Surgical Procedures. Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of the teeth.

How We Pay for Orthodontic Care. Because orthodontic treatment usually occurs over a long period of time, payments are made over the course of Your treatment. In order for Us to continue to pay for Your orthodontic care You must have continuous coverage under this Certificate.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your dental Provider should submit the necessary forms telling Us when Your appliance is installed. Payments are then made at six month intervals until the treatment is finished or coverage under this Certificate ends.

If Your orthodontic treatment is already in progress (the appliance has been installed) when You begin coverage under this Certificate, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that You are given while covered under this Certificate. We will not pay for any portion of Your treatment that was given before Your Effective Date under this Certificate.

What Orthodontic Care Does NOT Include. The following is not covered as part of Your orthodontic treatment:

- Monthly treatment visits that are billed separately -- these costs should already be included in the cost of treatment.
- Repair or replacement of lost, broken, or stolen appliances.
- Orthodontic retention or retainers that are billed separately -- these costs should already be included in the cost of treatment.
- Retreatment and services given due to a relapse.
- Inpatient or Outpatient hospital expenses, unless covered by the medical benefits of this Certificate.
- Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Note: For adult orthodontic services for cleft lip and cleft palate conditions, see the “Dental Related Services” benefit description.

Pediatric Vision Care

These vision care services are covered for Members until the end of the month in which they turn 19. To get In-Network benefits, use a Blue View Vision eye care Provider. For help finding one, try “Find a Doctor” on Our website, or call Us at the number on Your Identification Card.

Routine Eye Exam

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

Eyeglass Lenses

Standard plastic (CR39) eyeglass lenses up to 55mm are covered, whether they are single vision, bifocal, trifocal (FT 25-28) or progressive.

There are a number of additional covered lens options that are available through Your Blue View Vision Provider. See the “Schedule of Benefits (Who Pays What)” for the list of covered lens options.

Frames

Your Blue View Vision Provider will have a collection of frames for You to choose from. They can tell You which frames are included at no extra charge -- and which ones will cost You more.

Contact Lenses

Each Year, You get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options in a given Year. Your Blue View Vision Provider will have a collection of contact lenses for You to choose from. They can tell You which contacts are included at no extra charge - and which ones will cost You more.

Elective contact lenses are ones You choose for comfort or appearance.

Non-elective contact lenses are ones prescribed for certain eye conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses
- High ametropia exceeding -12D or +9D in spherical equivalent
- Anisometropia of 3D or more
- For patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

Note: We will not pay for non-elective contact lenses for any Member who has had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

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

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

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

The following services are not covered:

- Services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care services received from an Urgent Care Center or ambulance services related to an Emergency for transportation to a Hospital.
- Services by Out-of-Network Providers unless:
    - o The services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center; or
    - o The services are approved in advance by Us.

Medical Services

Your Medical benefits do not cover:

Abortions. We do not provide benefits for procedures, equipment, services, supplies, or charges for abortions for which federal funding is prohibited. Federal funding is allowed for abortions, where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a doctor, places the woman in danger of death unless an abortion is performed.

Affiliated Providers. Services 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 Holiday Charges. Additional charges beyond the Maximum Allowed Amount for basic and primary services requested after normal Provider service hours or on holidays.

Aids for Non-verbal Communication. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by HMO Colorado.

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, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

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 doctor is not a Covered Service. Non-Covered Services for ambulance include, but are not limited to, trips to:

- A doctor'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 doctor. Air ambulance services are not covered for transport to a Hospital that is not an acute care Hospital, such as a nursing Facility or a rehabilitation Facility, doctor's office, or Your home.

Applied Behavioral Treatment (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) for all indications except as described as a Covered Service in this Certificate, unless otherwise required by law.

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.

Autopsies and Post-mortem Testing.

Before Effective Date or After Termination Date. Charges for care You get before Your Effective Date or after Your coverage ends, except as written in this Certificate.

Charges Not Supported by Medical Records. Charges for services not described in Your medical records.

Charges Over the Maximum Allowed Amount. Charges over the Maximum Allowed Amount for Covered Services except for Surprise Billing Claims.

Clinical Trials. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Any investigational drugs or devices, non-health services required for You to receive the

treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-investigational treatments; or

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

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

Complications Resulting from Experimental or Investigational or non Medically Necessary Services or Treatment. Complications directly related to a service or treatment that is a non-Covered Service under this Certificate because it was determined by Us to be Experimental or Investigational or non-Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental or Investigational or non Medically Necessary service and would not have taken place in the absence of the Experimental or Investigational or non-Medically Necessary service.

Compound Drugs. Compound Drugs.

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 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 Certificate. 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.

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, to the extent authorization is required.

Custodial Care. Custodial care, convalescent care or rest cures. This exclusion does not apply to hospice services.

Delivery Charges. Charges for delivery of Prescription Drugs.

Dental Braces. For Dental braces except as specified as a Covered Service in this Certificate.

Dental Implants. For Dental implants except as specified as a Covered Service in this Certificate.

Dental Treatment. For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Certificate. “Dental treatment” includes, but is not limited to, preventive care, diagnosis,

treatment of or related to the teeth, jawbones or gums, including, but not limited to:

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

Doctor or Other Practitioners' Charges. Doctor or other practitioners' charges including:

- Doctor or other practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other non-telehealth based consultation or medical management service not involving direct (face-to-face) care with the Member except as specified as a Covered Service in this Certificate.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for Your care.
- Charges that are not documented in Provider records.
- For membership, administrative, or access fees charged by doctors 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.

Doctor Stand-by Charges. For stand-by charges of a doctor.

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

Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the Plan or Us.

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.

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

Drugs That Do Not Need a Prescription. Drugs that do not need a Prescription by federal law (including drugs that need a Prescription by State law, but not by federal law).

Durable Medical Equipment. Covered Services do not include Durable Medical Equipment except as specified as a Covered Service in this Certificate. Non-Covered Services or supplies include, but are not limited to:

- Orthopedic shoes or shoe inserts, except as specified as a Covered Service in this Certificate.
- Air purifiers, air conditioners, humidifiers.
- Exercise equipment, treadmills.
- Pools and spas.
- Elevators.
- Supplies for comfort, hygiene or beautification.
- Correction appliances or support appliances and supplies such as stockings.

Education/Training. For services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

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

Experimental or Investigational. Which are Experimental or Investigational or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental or Investigational 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 Investigational.

Eyeglasses/Contact Lenses. For prescription, fitting, or purchase of eyeglasses or contact lenses except as specified as a Covered Service in this Certificate. 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.

Note: For pediatric vision services, please see the “Pediatric Vision Care” benefit description.

Family/Self. 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

Genetic Testing and Counseling. Benefits are not provided for genetic testing or genetic counseling except as specified as a Covered Service in this Certificate.

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

Gynecomastia. For surgical treatment of gynecomastia.

Hair Loss or Growth Treatment. Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

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

Hospice Care. 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 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.

Hyperhidrosis. 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 infertility services or transgender surgery noted in this Certificate.

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.

In-vitro Fertilization (IVF) or Pre-implant Genetic Diagnosis (PGD) of Embryos. Services or supplies for in-vitro fertilization (IVF) or pre-implant genetic diagnosis (PGD) of embryos, whether provided or not provided in connection with infertility treatment, except where coverage is specifically required by law.

Maintenance Therapy. For maintenance therapy, other than covered habilitation therapies otherwise covered herein, 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.

Maternity and Newborn Care. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- 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 Equipment, Devices, and Supplies. We do not provide benefits for supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

Missed/Cancelled Appointments. For missed or cancelled appointments.

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

Non-approved Drugs. Drugs not approved by the FDA.

Non Authorized Travel Related Expenses. For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or as specified as a Covered Service in this Certificate.

Non-duplication of Medicare. Benefits are not provided that duplicate any benefits You are entitled to receive under Medicare. This exclusion applies to all Parts of Medicare in which You are entitled to or enrolled in without paying additional Premium.

Nonemergency Care Received in Emergency Room. For care received in an Emergency room that is not Emergency Care, except as specified as a Covered Service in this Certificate. This includes, but is not limited to, suture removal in an Emergency room.

Not Medically Necessary. Any services or supplies which are not Medically Necessary.

Nutritional and Dietary Supplements. For nutritional and dietary supplements, except as specified as a Covered Service in this Certificate 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.

Off Label Use. Off label use, unless We must cover the use by law or if We approve it.

Oral Appliances for Snoring. Medical and surgical treatment for snoring, except when provided as a

part of treatment for documented obstructive sleep apnea.

Orthodontic Services. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- 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.

Orthotic Devices, Shoes or Shoe Inserts. Benefits are not provided for orthotic devices, shoes or shoe inserts except as specified as a Covered Service in this Certificate. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

Outdoor Treatment Camps and/or Programs and/or Wilderness Programs.

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, except as specified as a Covered Service in this Certificate or as required by law.

Personal Care, Convenience and Mobile/Wearable Devices. For personal hygiene, environmental control, or convenience items including, but not limited to:

- Air conditioners, humidifiers, air purifiers;
- 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 doctor. This exclusion also applies to health spas or similar facility.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar facility;
- Personal comfort and convenience items during an Inpatient stay, including, but not limited to, daily television rental, telephone services, cots or visitor's meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly;
- Consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications;
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails);
- Safety helmets for Members with neuromuscular diseases; or

- Sports helmets.

Physical Exams and Immunizations - Other Purposes. Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

Private Duty Nursing. For private duty nursing services except as specified as a Covered Service in this Certificate.

Provider Services. You get from Providers that are not licensed by law to provide Covered Services, as defined in this Certificate. 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 Certificate, or recognized by Us.

Reconstructive Services. Reconstructive services, except as specified as a Covered Service in this Certificate, 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, except as specified as a Covered Service in this Certificate.

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

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- 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, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

Reversal of Sterilization. For reversal of sterilization.

Riot, Nuclear Explosion. For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

Self-Help Training/Care. For self-help training and other forms of non-medical self care, except as specified as a Covered Service in this Certificate.

Services Not Appropriate for Virtual Telehealth or Online Visits. Services that We determine require in-person contact and/or equipment that cannot be provided remotely.

Services Not Listed As Covered. Benefits are not provided for any service, procedure, or supply not listed as a Covered Service in this Certificate.

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

Spinal Decompression Devices. Spinal decompression devices. This includes, but is not limited to, vertebral axial decompression (Vax-D) and DRX9000.

Surrogate Pregnancy. Services or supplies provided to a person not covered under the Certificate 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 specified as a Covered Service in this Certificate or as required by law.

Teeth, Jawbone, Gums. For treatment of the teeth, jawbone or gums that is required as a result of a medical condition, except as expressly required by law, or as specified as a Covered Service in this Certificate.

Telephone/Internet Consultations. For telephone consultations or consultations via electronic mail or internet/website, except as required by law, or except as specified as a Covered Service in this Certificate.

Therapy - Other. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Gastric electrical stimulation
- Hippotherapy
- Intestinal rehabilitation therapy
- Prolotherapy
- Recreational therapy
- Sensory integration therapy (SIT)
- Home programs, on-going conditioning, or maintenance care

Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood Exclusions. 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.

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

Virtual Telehealth or Online Visits. Virtual telehealth and online visits do not include the use of facsimile, audio-only telephone, texting (outside of Our mobile app), electronic mail, or non-secure instant messaging. Benefits also do not include reporting normal laboratory or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for Referrals to Providers outside Our network, benefit Precertification or Provider to Provider discussions

except as approved under the “Benefits/Coverage (What is Covered)” section.

Vision Orthoptic Training. For vision orthoptic training.

Waived Copayment, Coinsurance, or Deductible. For any service for which You are responsible under the terms of this Certificate to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance 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 doctor supervision, except as specified as a Covered Service in this Certificate. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Weight Loss Surgery. Services and supplies related to bariatric surgery, or surgical treatment of obesity, except as specified as a Covered Service in this Certificate.

Workers’ Compensation. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment, except as specified as a Covered Service in this Certificate.

Prescription Drugs

Your Prescription Drug benefits do not cover:

- Administration charges for the administration of any drug except for covered immunizations as approved by Us or the PBM.
- An allergenic extract or vaccine.
- Charges Not Supported by Medical Records. Charges for Pharmacy services not related to conditions, diagnoses, and/or recommended medications described in Your medical records.
- Clinically Equivalent Alternatives. Certain Prescription Drugs may not be covered if You could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that, for most Members, will give You similar results for a disease or condition. If You have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of Your Identification Card, or visit Our website at www.anthem.com
- Compound Drugs. Compound Drugs.
- Contrary to Approved Medical and Professional Standards. Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges. Charges for delivery of Prescription Drugs.
- 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 specified in "Therapy Services Outpatient," or drugs specified in "Medical Supplies, Durable Medical Equipment and Appliances" in the "Benefits/Coverage (What is Covered)" section - they are Covered Services.
- Drugs not approved by the FDA.
- Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the Plan or Us.
- 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.
- Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by Us.
- Drugs That Do Not Need a Prescription. Drugs that do not need a Prescription by federal law (including drugs that need a Prescription by State law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that We must cover under State or federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.
- Drugs used for cosmetic purposes.
- Infertility Drugs. Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT), except as listed in the Certificate.
- Items Covered as Durable Medical Equipment (DME). Therapeutic DME, devices and supplies except peak flow meters, spacers, glucose monitors.
- Lost or Stolen Drugs. Refills of lost or stolen drugs.
- 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.

- Nutritional or Dietary Supplements. Nutritional and/or dietary supplements, except as described in this Certificate or that We must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that You can buy over-the-counter and those You can get without a written Prescription or from a licensed pharmacist.
- Off Label Use. Off label use, unless We must cover the use by law or if We, or the PBM, approve it.
- Onychomycosis Drugs. Drugs for onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items may not be Covered. Drugs, devices and products, or Prescription Drugs with over-the-counter equivalents and any drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device, or product. This includes Prescription Drugs when any version or strength becomes available over-the-counter.
- Services or Supplies From Family Members. Services prescribed, ordered, referred by or received from a member of Your immediate family, including Your spouse, domestic partner, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.
- Services We conclude are not Medically Necessary. This includes services that do not meet Our medical policy, clinical coverage, or benefit policy guidelines.
- Sexual Dysfunction Drugs. Drugs to treat sexual or erectile problems.
- Syringes. Hypodermic syringes except when given for use with insulin and other covered self-injectable drugs and medicine.
- Weight Loss Drugs. Any drug mainly used for weight loss.

Pediatric Dental Care

Your dental care services do not include services incurred for or in connection with any of the items below:

- Dental Care for Members age 19 and older, except as specified as a Covered Service in this Certificate.
- Dental services or healthcare services not specifically covered under the Certificate (including any Hospital charges, Prescription Drug charges and dental services or supplies that do not have an American Dental Association Procedure Code), except as specified as a Covered Service in this Certificate.
- Services of anesthesiologist, unless required by law.
- Anesthesia services, (such as intravenous or non-intravenous conscious sedation and general anesthesia) are not covered when given separate from a covered oral surgery service, 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, appliances or restorations that are necessary to alter, restore or maintain occlusion. This includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Dental services provided solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
- Case presentations, office visits, consultations.
- Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
- Enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the Certificate.
- Biological tests for determination of periodontal disease or pathologic agents, except as specified as a Covered Service in this Certificate.
- Collection of oral cytology samples via scraping of the oral mucosa, except as specified as a Covered Service in this Certificate.
- Separate services billed when they are an inherent component of another Covered Service.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
- Additional, elective or enhanced prosthodontic procedures including, but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Placement or removal of sedative filling, base or liner used under a restoration that is billed separately from a restoration procedure (such as a filling).

- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Oral hygiene instructions.
- Repair or replacement of lost or broken appliances.
- Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- For dental services received prior to the Effective Date of this Certificate or received after the coverage under this Certificate has ended.
- Dental services given by someone other than a licensed Provider (dentist or doctor) or their employees.
- Services to treat temporomandibular joint disorder (TMJ), except as specified as a Covered Service in this Certificate.
- Occlusal or athletic mouth guards.
- Implant services, including maintenance or repair to an implant or implant abutment.
- Dental services for which You would have no legal obligation to pay in the absence of this or like coverage.
- 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.
- Prosthodontic services (such as dentures bridges) and periodontal services (such as scaling and root planing).

Pediatric Vision Care

Your vision care services do not include services incurred for or in connection with any of the items below:

- Vision care for Members age 19 and older, except as specified as a Covered Service in this Certificate.
- 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.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- For services or supplies prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse or domestic partner, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports.
- For missed or cancelled appointments.
- For safety glasses and accompanying frames.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, including Inpatient or Outpatient Hospital vision care, except as specified as a Covered Service in this Certificate.
- Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
- For services or supplies not specified as a Covered Service in this Certificate.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, except as specified as a Covered Service in this Certificate.
- For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- No benefits are available for frames or contact lenses purchased outside of Our formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.
- Blended lenses.
- Oversize lenses.
- For sunglasses.

SECTION 9. MEMBER PAYMENT RESPONSIBILITY

This section describes how Your claims are administered, explains the Cost Sharing features of Your Plan, and outlines other important provisions. The specific Cost Sharing features, and the applicable benefit percentages and/or limitations, are outlined in the "Schedule of Benefits (Who Pays What)" section.

We consider Covered Services to be incurred on the date a service is provided. This is important because You must be actively enrolled on the date the service is provided.

Cost Sharing Requirements

Cost Sharing is how We share the cost of healthcare services with You. It means what We are responsible for paying and what You are responsible for paying. You meet Your Cost Sharing requirements through Your payment of Copayments, Deductibles and/or Coinsurance (as described below).

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

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

The contracts between Us and Our In-Network Providers include a "hold harmless" clause which provides that You cannot be responsible to the Provider for claims owed by Us for healthcare services covered under this Certificate.

Copayment

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

Coinsurance

Coinsurance means the percentage of the Maximum Allowed Amount that is Your share of the cost for a Covered Service. For example, if Your Coinsurance 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. Coinsurance is required for Covered Services until the Out-of-Pocket Maximum is reached for each Benefit Period. Once the Out-of-Pocket 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 HMO Colorado reimburses for covered benefits. A Copayment may be required before the Deductible for certain Covered Services. The Deductible amount is listed in the "Schedule of Benefits (Who Pays What)" section. A new Deductible is required for each Benefit Period.

Deductible Calculation

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

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. 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 “Schedule of Benefits (Who Pays What)” section.

Out-of-Pocket Maximum

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

Out-of-Pocket Maximum Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a Calendar Year apply to the Out-of-Pocket Maximum.

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

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

The family membership Out-of-Pocket Maximum is also applicable for newborn and adopted children for the first 31-day period following birth or adoption whether or not the child is enrolled following the first 31-day period.

Out-of-Pocket Limit Exceptions

Please read this section very carefully. Not all money that You pay toward Your healthcare costs are counted toward Your Out-of-Pocket Maximum.

Amounts You incur towards Your Deductible, Copayments and/or Coinsurance count towards the Out-of-Pocket Maximum. However, the following will never count towards the Out-of-Pocket Maximum, nor will they ever be paid under this Plan:

- Amounts exceeding the Maximum Allowed Amount;
- Amounts over any Plan maximum or limitation; and/or
- Expenses for services not covered under this Certificate.

Services Received from Out-of-Network Providers

Covered Services that are not obtained from an In-Network Provider, or that are not an Authorized Service will be considered Out-of-Network. The only exceptions are Emergency Care, or Emergency ambulance services.

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 Maximum. See the "Schedule of Benefits (Who Pays What)" for those services which have a Benefit Period maximum.

If, within the same Year, You replace any HMO Colorado individual medical plan with another HMO Colorado individual medical plan, any benefits applied toward the Deductible or In-Network or Out-of-Network Provider Out-of-Pocket Maximum, will be applied toward the Deductible and In-Network or Out-of-Network Provider Out-of-Pocket 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.

Balance Billing

In-Network Providers are prohibited from balance billing. An In-Network Provider has signed an agreement with HMO Colorado to accept Our determination of the Maximum Allowed Amount or reimbursement rate for Covered Services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of this determination or negotiated fee, except what is due under the Certificate, e.g., Deductibles (if any) or Coinsurance. When You receive Covered Services from an Out-of-Network Provider, including in an Emergency or when services have been previously authorized, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges unless You receive a Surprise Billing Claim.

Maximum Allowed Amount

General

This provision describes how We determine the amount of reimbursement for Covered Services.

Reimbursement for services rendered by In-Network and Out-of-Network Providers is based on Your Certificate's Maximum Allowed Amount for the Covered Service that You receive. Please also see "Inter-Plan Programs" provision for additional information.

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

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

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

Generally, services received from an Out-of-Network Provider under this Certificate are not covered except for Emergency care, or when services have been previously authorized by Us. Except for Surprise Billing Claims, when You receive Covered Services from an Out-of-Network Provider either in an Emergency or when services have been previously authorized, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When You receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means We have determined that the claim was

submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

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

Provider Network Status

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

An In-Network Provider is a Provider who is in the managed network for this specific product or in other closely managed specialty network, or who has a participation contract with Us. For Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for Your Certificate is the rate the Provider has agreed with Us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding an In-Network Provider or visit Our website 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 Blue Shield Association rules governing claims filed by certain ancillary Providers. If You use an Out-of-Network Provider, Your entire claim will be denied except for Emergency care, or unless the services were previously authorized by Us.

Except for Surprise Billing Claims, We will calculate the Maximum Allowed Amount for Covered Services You receive in an Emergency or if previously authorized from an Out-of-Network Provider, using one of the following:

1. An amount based on Our Out-of-Network 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 Us, 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, We will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers’ fees and costs to deliver care; or
4. An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through Case Management;
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider;
6. An amount required by applicable law; or
7. An amount based on the Medicaid fee schedule established by the State. When basing the Maximum Allowed Amount upon the level or method of reimbursement established by the State

for Medicaid, We will update such information no less than annually.

Providers who are not contracted for this product, but are contracted for other products with Us are also considered Out-of-Network. For this Certificate the Maximum Allowed Amount for services from these Providers will be one of the methods shown above unless the contract between Us and that Provider specifies a different amount or if Your claim involves a Surprise Billing Claim.

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

Except when You get Covered Services from an Out-of-Network Provider at an In-Network Facility in Colorado (and You did not knowingly choose the Out-of-Network Provider), or when You get Covered Emergency Services from an Out-of-Network Provider at a Facility in Colorado, an Out-of-Network Provider may send You a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount unless Your claim involves a Surprise Billing Claim. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing an In-Network Provider will likely result in lower out of pocket costs to You. Please call Member Services for help in finding an In-Network Provider or visit Our website at www.anthem.com.

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

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by Us using Prescription Drug cost information provided by the 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).

We will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by Your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of Your Certificate and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Your day/visit limits.

The following are examples for illustrative purposes only; the amounts shown may be different than this Certificate's Cost Share amounts; see Your "Schedule of Benefits (Who Pays What)" for Your applicable amounts.

Example: Your Certificate has a Coinsurance Cost Share of 20% for In-Network services after Deductible has been met.

You undergo a nonemergency surgical procedure in an In-Network Hospital in Colorado. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- The Out-of-Network anesthesiologist's charge for the service is $1200, the Maximum Allowed Amount is $1,000. Your Coinsurance responsibility is 20% of $1,000, or $200. You are not responsible for the $200 difference between the anesthesiologist's charge and the Maximum

Allowed Amount.

- You choose an In-Network surgeon. The charge was $2500. The Maximum Allowed Amount for the surgery is $1500; Your Coinsurance responsibility when an In-Network surgeon is used is 20% of $1500, or $300. We allow 80% of $1500, or $1200. The In-Network surgeon accepts the total of $1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be $300.
- You choose an Out-of-Network surgeon. Unless previously authorized by Us, all services will be denied and You will be responsible for the total amount billed.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available for the Covered Service, We may authorize the In-Network Cost Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstance, You must contact Us in advance of obtaining the Covered Service. We also may 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 an In-Network Cost Share amount to apply to a Covered Service received from an Out-of-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge except for Surprise Billing Claims. Please contact Member Services for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Certificate's Cost Share amounts; see Your "Schedule of Benefits (Who Pays What)" for Your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no In-Network Provider for that specialty available to You. You contact Us in advance of receiving any Covered Services, and We authorize You to go to an available Out-of-Network Provider for that Covered Service and We agree that the In-Network Cost Share will apply.

Your Certificate has a $25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the In-Network Cost Share amount to apply in this situation, You will be responsible for the In-Network Copayment of $25 and We will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is $500, if You receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Your total out of pocket expense would be $25.

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

Inter-Plan Arrangements

Out-of-Area Services

Overview

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

When You receive care outside of the HMO Colorado Service Area, and outside Colorado You will receive it from one of two kinds of Providers. Most Providers (“participating Providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some Providers (“non-participating Providers”) don’t contract with the Host Blue. We explain below how We pay both kinds of Providers. HMO Colorado covers only limited healthcare services received outside of the HMO Colorado Service Area. For example, Emergency Care or Urgent Care services received at an Urgent Care Center obtained outside the HMO Colorado Service Area is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by Us.

Inter-Plan Arrangements Eligibility - Claim Types

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

A. BlueCard® Program

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

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

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

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

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

B. Special Cases: Value-Based Programs

BlueCard® Program

If You receive Covered Services under a value-based program inside a Host Blue’s service area, You

will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to HMO Colorado through average pricing or fee schedule adjustments. Additional information is available upon request.

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

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

D. Non-participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of HMO Colorado's Service Area by non-participating Providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable State or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the non-participating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or State law, as applicable, will govern payments for Out-of-Network emergency services.

2. Exceptions

In certain situations, We may use other pricing methods, such as billed charges, the pricing We would use if the healthcare services had been obtained within the HMO Colorado Service Area, or a special negotiated price to determine the amount We will pay for services provided by non-participating Providers. In these situations, You may be liable for the difference between the amount that the non-participating Provider bills and the payment We make for the Covered Services as set forth in this paragraph.

E. Blue Cross Blue Shield Global® Core Program

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

When You are traveling abroad and need medical care, You can call the Blue Cross Blue Shield Global ® Core Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 1-800-810-2583. Or You can call them collect at 1-804-673-1177.

Keep in mind, if You need emergency medical care, go to the nearest hospital. There is no need to call before You receive care. Please refer to the "Requesting Approval for Benefits."

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

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

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

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

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

When You need Blue Cross Blue Shield Global® Core claim forms You can get international claims

forms in the following ways:

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

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

Notice of Claim and Proof of Loss

After You get Covered Services, We must receive written notice of Your claim in order for benefits to be paid.

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

  Out-of-Network claims must be submitted within 180 days.

  The claim must have the information We need to determine benefits. If the claim does not include enough information, We will ask You for more details and inform You of the time by which We need to receive that information. Once We receive the required information, We will process the claim according to the terms of Your Plan.

  Please note that failure to submit the information We need by the time listed in Our request could result in the denial of Your claim, unless State or federal law requires an extension. Please contact Member Services if You have any questions or concerns about how to submit claims.

Payment of Benefits

Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by You or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment.

If We fail to pay or deny a clean claim in 30 days for a claim filed electronically; or in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Colorado law.

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.

Federal/State Taxes/Surcharges/Fees

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

Claim Denials

If benefits are denied, in whole or in part, HMO Colorado will send the Member a written notice within the established time periods described in the section "Payment of Benefits." The Member or the Member's duly authorized representative may appeal the denial as described in the "If You Have a Complaint or an Appeal" section below. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provisions(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits.

If the denial involves a Utilization Review determination, the notice will also specify:

- Whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge;
- That an explanation of the scientific or clinical judgment for a decision based on Medical Necessity, Experimental or Investigational treatment or a similar limitation is available to the Member upon request and at no charge.

Where to Send Your Claim

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:

HMO Colorado Claims
P.O. Box 5747
Denver, CO 80217-5747

Right of Recovery and Adjustment

Whenever payment has been made in error, or in excess of the maximum amount of payment necessary to satisfy the provisions of this Plan, We will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustments to claims. In most instances, such recovery or adjustment activity shall be limited to the Calendar Year in which the error is discovered.

We have oversight responsibility of compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, We have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. We may not give You notice of overpayments made by Us or You if the recovery method makes providing such notice administratively burdensome.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate will be responsible for any charge for services.

Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement from Us to help You understand the coverage You are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by Your coverage;
- The amount for which You are responsible (if any);
- General information about Your Appeals rights and for information regarding the right to bring an action after the Appeals process.

Payment Owed to You at Death

Upon the death of a Member, claims will be payable in Our discretion to either the Member's estate or a beneficiary designated to Us. If the Provider is an In-Network Provider, claims payments will be made to the Provider.

Claims Review for Fraud, Waste and Abuse

HMO Colorado has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members 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.

We also may identify certain Pharmacies to review for potential fraud, waste, abuse or other inappropriate activity when claims data suggests there may be inappropriate billing practices. If a Pharmacy is selected, then We may use one or more clinical utilization management strategies in the adjudication of claims submitted by this Pharmacy, even if those strategies are not used for all Pharmacies delivering services to this Plan’s Members.

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 healthcare services in a cost-efficient manner.

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

The Programs are not intended to affect Your access to healthcare. The Program payments are not made as payment for specific covered healthcare services provided to You, but instead, are based on the In-Network Provider’s achievement of these pre-defined standards. You are not responsible for any Copayment or Coinsurance amounts related to payments made by Us or to Us under the Program(s), and You do not share in any payments made by In-Network Providers to Us under the Program(s).

Relationship of Parties (HMO Colorado and In-Network Providers)

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

Your healthcare 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.

SECTION 11. GENERAL POLICY PROVISIONS

Medicare-Eligible Members

Applicants who are not eligible for Medicare 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 entitled to or enrolled in Medicare Parts A, B, C and/or Part D, may continue with this coverage as secondary to any Medicare benefits. Medicare will be the primary carrier for such Members.

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 Certificate 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 Certificate) 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 Certificate 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.

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.

Changes in Premiums

The Premium for this Certificate may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records at least 30 days prior to such change. Any such change will apply to Premiums due on or after the effective date of change. If advance Premiums have been paid beyond the effective date of a rate change, such Premiums will be adjusted as of that effective date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

Payment of the Premium by the Subscriber shall serve as notice of the Subscriber's acceptance of the change.

How to Pay Your Premium

After making Your initial Premium payment, You can make future payments by the following methods:

- online at www.anthem.com
- by mail using the address on Your Premium notice

- by authorizing Us to automatically deduct Your Premium payment from Your financial institution account every month
- by using Our mobile application
- pay in person at any approved retailer found on the mobile application

To learn more about any of these options, please contact Member Services at the number on the back of Your Identification Card.

Administrative Fee

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 HMO Colorado for any reason.

Premiums Paid by a Third Party

HMO Colorado will accept Premium payments made on behalf of Subscribers if the Premium is paid by the following persons or entities:

- The Ryan White HIV/AIDS Program;
- Other Federal and State government programs that provide Premium and Cost Sharing support for specific individuals;
- Indian tribes, tribal organizations and urban Indian organizations; or
- A relative or legal guardian on behalf of a Subscriber.

Unless required by law, HMO Colorado does not accept Premium payments from third parties that are not listed above. Examples of third parties from whom We will not accept Premium payments include, but are not limited to, Providers, Hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract, commercial entities with a direct or indirect financial interest in the benefits of the contract and employers that offer coverage under an employer health plan.

Policies, Procedures and Pilot Programs

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

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

Confidentiality and Release of Information

Applicable State and federal law requires Us to undertake efforts to safeguard Your medical information.

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

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

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts We need.

Subject to applicable privacy restrictions, We may obtain needed facts from, or give them to, any other organization or person. We need not tell You or obtain Your consent to do this. Each person claiming benefits under this Plan must give Us any facts We need to pay the claim.

Notice of Privacy Practices

We are committed to protecting the confidential nature of Members' medical information to the fullest extent of the law. In addition to various laws governing Member privacy, We have Our own privacy policies and procedures in place designed to protect Member 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 or contact Our Member Services department.

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.

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. In such an event, however, We shall use reasonable efforts to perform Our respective obligations.

Decision Makers

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

Refusal to Follow Recommended Treatment

If a Member refuses treatment that has been recommended by Our In-Network Provider, the Provider may decide that the Member's refusal compromises the Provider-patient relationship and obstructs the provision of proper medical care. Providers will try to render all necessary and appropriate professional services according to a Member's wishes, when they are consistent with the Provider's judgment. If a Member refuses to follow the recommended treatment or procedure, the Member is entitled to see another Provider of the same specialty for a Second Opinion. The Member can also pursue the Appeal and grievance process.

Entire Contract Changes

This Certificate including attached papers if any constitutes the entire contract of insurance. No change in this Certificate 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 Certificate 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 healthcare 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 laboratories. Ask what the insurance company will be charged for the tests;
- Always review the Explanation of Benefits received from Us. If there are any discrepancies, call Our Member Services; and
- Be very cautious about giving Your health insurance coverage information over the phone.

If fraud is suspected, You should contact Our Member Services.

Misstatement of Age

If the Premium for this Certificate is based on Your age and if Your age has been misstated, the benefits will be those the Premium paid would have purchased at the correct age.

Notice

Any notice given by HMO Colorado to a Subscriber shall be sufficient if mailed to the Subscriber at his or her address as it appears in Our records. Notice given to Us must be sent to Our address as shown in this Certificate. HMO Colorado, or a Member may, by written notice, indicate a new address for giving notice.

Not Liable for Provider Acts or Omissions

We are not liable for the acts or omissions by any individuals or institutions furnishing care or services to You.

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 Certificate.

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 with 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 Certificate are for reference only and are not to be used by themselves for interpreting the terms of the Certificate.

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to examine the Member when and as often as it may reasonably be required during the pendency of a claim and to make an autopsy in case of death where it is not prohibited by law.

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.

Third Party Liability

These provisions apply when We pay benefits as a result of injuries or illness You sustained and You have a right to a recovery or have received a recovery as a result of actions or omissions of a third party. We will automatically have a lien upon any recovery. Our lien will equal the amount of benefits We pay on Your behalf for injuries, disease, condition or loss You sustained as a result of any act or omission for which a third party is liable. Our lien will not exceed the amount We actually paid for those services. We have a first priority right to recover Our lien.

In this section, “recovery” means money You (or Your estate, parent, trustee or legal guardian) receive, are entitled to receive, or have a right to receive, whether by judgment, award, settlement or otherwise as a result of injury or illness caused by the third party, regardless of whether liability is contested. In this section “third party” refers to any person or entity who is legally responsible in relation to the injuries or illnesses sustained by You for which We paid benefits, including but not limited to the party(ies) who caused the injury or illness (“tortfeasor”), the tortfeasor’s insurer, the tortfeasor’s indemnifier, the tortfeasor’s guarantor, the tortfeasor’s principal or any other person or entity responsible or liable for the tortfeasor’s acts or omissions, Your own insurer (underinsured or uninsured motorist benefits, medical payments, no fault benefits, personal injury protection, etc.), or any other person, entity, policy or plan that may be liable or responsible in relation to the injuries or illness, to the extent permitted by law.

Subrogation or reimbursement under this Plan may only be permitted if You have been fully compensated, and the amount recoverable by Us may be reduced by a pro rata share of Your reasonable attorney’s fees and costs, if State law so requires.

Subrogation and Right of Reimbursement

- You must reimburse Us the full amount of Our lien.
- If We paid the Provider on a capitated basis, Our lien will not exceed 80% of the usual and customary charges for those services in the geographic area in which they were rendered.
- Our rights are not limited by any allocation or characterization made in a settlement agreement or court order.
- If You fail to repay Us, fail to cooperate or Our lien is otherwise not recovered by Us, We shall be entitled to deduct any of the unsatisfied portion of Our lien or the amount of Your recovery, whichever is less, from any future benefit under the Plan.
- In the event that You fail to disclose to Us the amount of Your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of Our lien or the amount of Your settlement, whichever is less, directly from the Providers to whom We have made payments. In such a circumstance, it may then be Your obligation to pay the Provider the full billed amount, and We would not have any obligation to pay the Provider.

Member's Duties

- Your signed application for coverage and/or Your receipt of benefits under this Plan authorizes and/or acknowledges each of Our rights set forth in this section.
- You, or Your attorney, must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to You occurred and all information regarding the parties involved.
- You agree to advise Us, directly or through Your attorney, in writing of Your claim against a third party, or a claim against Your own insurance, within 60 days of making such claim, unless a shorter period of time is prescribed by law, and that You or Your attorney will take such action, furnish such information and assistance, and execute such papers as We may require to facilitate enforcement of Our lien rights.
- Relevant information includes, but is not limited to, police reports, pleadings, settlement agreements, and communications with any party regarding the accident, incident, injury or illness.
- Neither You, nor Your attorney, shall take any action that may prejudice Our rights or interests under this section.
- You and/or Your attorney must cooperate with Us in the investigation, settlement and protection of Our rights.
- You and/or Your attorney must immediately notify Us if a trial is commenced, if a settlement occurs or is consummated, or if potentially dispositive motions are filed in a case.
- You and/or Your attorney must hold in trust the extent of Our lien that is recoverable by Us under the law and the recovery must not be dissipated or disbursed until such time as We have been repaid in accordance with these provisions.
- If You, or Your attorney, fail to give Us notice, fail to cooperate with Us, or intentionally take any action that prejudices Our rights, You will be in material breach of this agreement. In the event of such material breach, You will be personally responsible and liable for reimbursing to Us the amount of benefits We paid.
- If You, or a person or entity on Your behalf, obtains a recovery that is less than the sum of all damages You incurred, You are required to provide notice within 60 days of receipt of such recovery. The notice to Us must include:
  - The total amount and source of the recovery;
  - The coverage limits applicable to any available insurance policy, contract, or benefit plan; and
  - The amount of any costs charged to the injured party.
- Recovery obtained pursuant to a settlement containing a confidentiality provision is unenforceable as to the disclosure of the above required information.
- We have the right to dispute any contention that You have not been fully compensated, including through arbitration or as otherwise allowed by law.

Nothing in this Plan shall be construed to limit Our right to utilize any remedy provided by law to enforce Our rights to recover Our lien.

Any action that interferes with Our right to recover Our lien may result in the termination of coverage as allowed by law for You and Your covered Dependents.

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

Severability

In the event that any provision in this Certificate is declared legally invalid by a court of law or determined to be illegal due to the enactment of new legislation or regulations, such provision will be severable and all other provisions of the Certificate will remain in force and effect.

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.

Right to Change Plan

No agent or employee of the Plan or other person, except an authorized officer of the Plan, has authority to waive, even if by providing incomplete or incorrect information, any conditions or restrictions or to change the form or content of this Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information. Such changes can be made only through a written authorization, signed by an officer of the Plan.

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.

Care Coordination

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

Medical Policy and Technology Assessment

HMO Colorado reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental / Investigational status or Medical Necessity of new technology. Guidance and external validation of 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.

Program Incentives

We may offer incentives from time to time, at Our discretion, in order to introduce You to covered programs and services available under this Certificate. We may also offer, at Our discretion, the ability for You to participate in certain voluntary health or condition focused digital applications or use other technology based interactive tool, or receive educational information in order to help You stay engaged and motivated, manage Your health, and assist in Your overall health and well-being. The purpose of these programs and incentives include, but are not limited to, making You aware of cost effective benefit options or services, helping You achieve Your best health, encouraging You to update Member-related information and encouraging You to enroll automatically to pay Premiums electronically. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member Cost Share. Acceptance of these incentives is voluntary as long as HMO Colorado offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue an incentive or a program for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.

Value-Added 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 Certificate 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.

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 Share 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.)

MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You have rights and responsibilities when receiving healthcare. As Your healthcare partner, We want to make sure Your rights are respected while providing Your health benefits. That means giving You access to Our network of doctors and other healthcare professionals, who help You make the best decisions for Your health.

You have the right to:

- Speak freely and privately with Your doctors and other healthcare professionals about healthcare options and treatment needed for Your condition, no matter what the cost or whether it is covered under Your Plan.
- Work with Your doctors and other healthcare professionals to make choices about Your healthcare.
- 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.
- Receive information You need to fully engage with Your health Plan, and also share Your feedback. This includes:
    - Our company and services;
    - Our network of doctors and other healthcare professionals;
    - Your rights and responsibilities;
    - 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 receive in the future. This includes asking Your doctors and other healthcare professionals to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a doctor 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 medical benefits under the Plan and ask for help if You have questions.
- Follow all medical Plan rules and policies.
- Choose an In-Network Primary Care Physician, also called a PCP, if Your health Plan requires it.
- Treat all healthcare professionals and staff with respect.
- Keep all scheduled appointments. Call Your doctor's office if You may be late or need to cancel.
- Understand Your health challenges as well as You can and work with Your doctors and other healthcare professionals to create an agreed upon treatment plan.
- Inform Your doctors and other healthcare professionals if You do not understand the type of care and Your actions that they are recommending.
- Follow the treatment plan that You have agreed upon with Your doctors and other healthcare professionals.
- Share the information needed with Us, Your doctors, and other healthcare professionals to help You get the best possible care. This may include information about other health insurance benefits You have in addition to Your coverage with Us.
- Inform Member Services if You have any changes to Your name, address or family members covered under Your Plan.

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

We are here to provide high-quality benefits and service to Our Members. Benefits and coverage for services given under the Plan are overseen by Your Certificate and not by this Member Rights and Responsibilities statement.

We value Your feedback regarding the benefits and service provided under Our policies and Your overall thoughts and concerns regarding Our operations. If You have any concerns regarding how Your benefits were applied or any concerns about services You requested which were not covered under this Certificate, You are free to file a complaint or Appeal as explained in this Certificate. If You have any concerns regarding a participating Provider or Facility, You can file a grievance as explained in this Certificate. And if You have any concerns or suggestions on how We can improve Our overall operations and service, We encourage You to contact Member Services.

SECTION 12. TERMINATION/NONRENEWAL/ CONTINUATION

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 or her coverage with appropriate notice to the Exchange;
2. The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage Dependent, moves outside the Service Area, etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date);
3. The Member fails to pay his or her Premium, and the grace period has been exhausted;
4. Rescission of the Member's coverage;
5. The QHP terminates or is decertified;
6. The Member changes to another QHP;
7. The Member was enrolled in a QHP without his or her knowledge or consent by a third party, including by a third party with no connection with the Exchange; or
8. The QHP Issuer may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP Issuer as required by law.

"Grace period" refers to either:

1. The three month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the three month grace period; or
2. Any other applicable grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1. In the case of termination initiated by the Member, the last day of coverage is:
   a) The termination date specified by the Member, if reasonable notice is provided;
   b) 14 days after the termination is requested, if the Member does not provide reasonable notice; or
   c) On a date determined by the Member's QHP Issuer, if the Member's QHP Issuer is able to implement termination in fewer than 14 days and the Member requests an earlier termination effective date.
2. If the Member is newly eligible for Medicaid, Children's Health Insurance Program (CHIP), or the Basic Health plan, the last day of coverage is the day before such coverage begins.
3. In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage Dependent, move outside the Service Area, etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4. In the case of a termination for non-payment of Premium and the three month grace period required

for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the three month grace period.

5. In the case of a termination for non-payment of Premium, and the individual is not receiving Advance Payments of Premium Tax Credit, the last day of coverage is the last day of the grace period.
6. In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7. The day following the Member's death. When a Subscriber dies, the surviving spouse or domestic partner of the deceased Subscriber, if covered under the Certificate, shall become the Subscriber.

"Reasonable notice" is defined as 14 days prior to the requested effective date of termination.

Guaranteed Renewable

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

- Eligibility criteria as a Qualified Individual continues to be met.
- There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Certificate.
- This Certificate has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP Issuer 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 Years after the Effective Date of this Certificate, 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 Certificate as of the original Effective Date. Additionally, if within two 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 Dependent 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 Certificate.

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/Coinsurance made or Premium paid for such services. After the two 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.

Time Limit on Certain Defenses

After two Years from the date of issue of this Certificate, 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 Certificate) commencing after the expiration of such two-Year period.

The foregoing 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.

Discontinuation of Coverage

We can refuse to renew Your contract 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 with at least 90 days' notice of the discontinuation and with at least 180 days' notice if We are discontinuing all individual products in the State. In addition, You will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage may remain in effect and refers to either the three month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the contract is terminated. In order for a Premium to be considered paid during the grace period, We must receive it by the last day of the grace period. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the three month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to HMO Colorado's right to terminate the contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the three month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Certificate has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Certificate will stay in force unless prior to the date Premium payment is due You give timely written notice to Us that the contract is to be terminated. If You do not make the full Premium payment during the grace period, the contract will be terminated on the last day of the grace period. You will be liable to Us for the Premium payment due including for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the grace period.

After Termination

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

the annual open enrollment period.

Removal of Members

A Subscriber may terminate the enrollment of any Member from the Plan. 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 Precertification 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 the 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, Your continuity of care request, Your 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 Member Services. A trained staff member will try to clear up any confusion about the matter. They will also try to resolve Your complaint. If You prefer, You can send a written complaint to this address:

HMO Colorado
Member Services 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:

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

Dental Coverage Appeals

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

HMO Colorado
P. O. Box 1122
Minneapolis, MN 55440-1122

Blue View Vision Coverage Appeals

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

Blue View Vision
P.O. Box 1122
Minneapolis, MN 55440-1122

You don't have to file a complaint before You file an Appeal. A written Appeal must state plainly the

reason(s) why You disagree with Our claim decision, Our refusal to authorize or cover a requested service or supply, or how We calculated the benefit. The Appeal should include any pertinent documents and medical records not originally submitted with the claim or request for the service or supply and any other information You feel may have a bearing on the decision. Also, please include the following details with Your Appeal if You have them:

- The Member's name, address and phone number;
- The identification number as shown on Your Identification Card (including the three letter prefix);
- The name of the Provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which You don't agree; and
- Any bills that You have received from the Provider.

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 healthcare professionals. For appeals of claims involving Utilization Review, You can either submit a written appeal or (if Your appeal is not an expedited appeal) You can participate in a review meeting.

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. There is no minimum dollar amount for a claim to be eligible for an external review. 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 Member Services Department. Once it's filled out, You need to send it to Us.

You can ask for an independent external review within four 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 doctor certifies in writing that the requested service would be significantly less effective if not promptly initiated and certifies that either:
    - Standard healthcare 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 doctor qualified to practice in the area of medicine appropriate to treat Your condition, there is no available standard healthcare service or treatment covered by this Certificate 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:

Grievance and Appeals
700 Broadway
Denver, CO 80273

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 healthcare coverage in Colorado, please call the Division of Insurance at 1-303-894-7490. 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 HMO Colorado goes above the limit of Small Claims court, then Your case will be decided by Binding Arbitration. If it does, You and HMO Colorado 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 Certificate. 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 HMO Colorado. 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 Certificate.

No action in law or in equity shall be brought to recover on this Certificate before the expiration of 60 calendar days after a claim has been filed according to the requirements of this Certificate. 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 Certificate.

Prescription Drug List Exceptions

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 Certificate 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 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 Certificate. 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.

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 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 Member Services 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 doctor, a Hospital or any other Provider of the Subscriber's healthcare services. 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 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 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 Certificate, any Premium then due and unpaid or covered by any note or written order may be deducted therefrom.

SECTION 15. DEFINITIONS

The following terms, defined in this section, are capitalized throughout the Certificate so they are easy to identify.

Advance Payments of the Premium Tax Credit (APTC)
Payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian

An individual who is a member of a federally recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Appeal

A formal request by You or Your representative for reconsideration of a decision not resolved to Your satisfaction. See the “If You Have a Complaint or an Appeal” section of this Certificate.

Applied Behavior Analysis

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

Authorized Service

A Covered Service rendered by any Provider other than a network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the network level. For more information, see the “Member Payment Responsibility” section.

Autism Services Provider

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

Autism Spectrum Disorders or ASD

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

Autism Treatment Plan

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

Benefit Period/Year

The period of time that We pay benefits for Covered Services. Generally, the Benefit Period/Year is a Calendar Year for this Plan, as listed in the ”Schedule of Benefits (Who Pays What).” If Your coverage ends earlier, the Benefit Period/Year ends at the same time.

Biosimilars

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

Birth Abnormality

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

Brand Drugs

Prescription Drugs that We classify as Brand Drugs or Our PBM has classified as Brand Drugs through use of an independent proprietary industry database.

Calendar Year

A period beginning on January 1 and ending on December 31 of the same year.

Certificate of Coverage (Certificate)

This summary of the terms of Your benefits.

Coinsurance

The percentage of the Maximum Allowed Amount that You pay for some Covered Services.

Congenital Defect

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

Controlled Substances

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

Copayment

A fixed amount You pay for a Covered Service, usually when You receive the service. The amount can vary by the type of Covered Service. The Copayment does not apply to the Deductible.

Cost Share (Cost Sharing)

The amount which the Member is required to pay for Covered Services. Where applicable, Cost Share can be in the form of Copayments, Coinsurance and/or Deductibles.

Covered Services

Services, supplies or treatments which are:

- Medically Necessary or otherwise specifically included as a benefit and that is listed under the “Benefits/Coverage (What is Covered)” section;
- Within the scope of the Provider’s license;
- Rendered while coverage under this Certificate is in force;
- Not Experimental or Investigational or not covered by this Certificate; and
- Authorized in advance by Us if such preauthorization is required in Certificate.

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

The amount of charges You must pay for any Covered Services before any benefits are available to You under this coverage. Your Deductible is stated in Your "Schedule of Benefits (Who Pays What)."

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.

Note: For adult orthodontic services for cleft lip and cleft palate conditions, see the Dental Related Services benefit description.

Dependent

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

Designated Pharmacy Provider

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

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 when a Member's coverage begins under this Certificate.

Emergency Medical Condition (Emergency)

A medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- placing the health of the individual or another person (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 or behavioral health 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.

Exchange

A governmental agency or non-profit entity that makes Qualified Health Plans such as this plan available to Qualified Individuals.

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 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 subsection under the “Benefits/Coverage (What is Covered)” section in this Certificate 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 doctors, other medical professionals or facilities, or by other treating doctors, 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 doctors, other medical professionals or facilities or by other treating doctors, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply;
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

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

Facility

A facility including but not limited to, a Hospital, freestanding ambulatory surgical facility, chemical dependency treatment facility, Residential Treatment Center, Skilled Nursing Facility, Home Healthcare Agency or mental health facility, as defined in this Certificate. The Facility must be licensed, accredited, registered and approved by the Joint Commission or The Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by Us.

Generic/Generic Drugs

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

Habilitative Services

Healthcare services and devices that help a person 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.

HMO Colorado

A health maintenance organization, organized under the laws of the State of Colorado, doing business as HMO Colorado, Inc. referred to in this Certificate as “Us”, “We”, or “Our.”

Home Delivery Pharmacy

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

Home Healthcare Agency

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

- Provides skilled nursing and other services on a visiting basis in the Member’s home; and
- Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending doctor.

Hospital

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

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

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

1. Nursing care

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

Identification Card/ID Card

A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about Your coverage. It is important to carry this card with You.

In-Network

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.

In-Network Pharmacy

An In-Network Pharmacy is a Pharmacy that has an In-Network Pharmacy agreement in effect with or for Our benefit at the time services are rendered. In-Network Pharmacies may be based on a restricted network, and may be different than the network of In-Network Pharmacies for Our other products. To find an In-Network Pharmacy near You, call Pharmacy Member Services at the telephone number on the back of Your Identification Card.

Inpatient

A Member who receives care as a registered bed patient in a Hospital or other Facility where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Intensive Outpatient Program

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

Interchangeable Biologic Product

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

Maintenance Medication

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 Pharmacy Member Services at the number on the back of Your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowed Amount

The maximum amount that We will allow for Covered Services You receive. For more information, see the "Member Payment Responsibility" section.

Medicaid

Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

Medically Necessary (Medical Necessity)

The diagnosis, evaluation and treatment of a condition, illness, disease or injury that We solely decide to be:

- Medically appropriate for and consistent with Your symptoms and proper diagnosis or treatment of Your condition, illness, disease or injury;
- Obtained from a doctor or Provider;
- Provided in line with medical or professional standards;
- Known to be effective, as proven by scientific evidence, in improving health;
- The most appropriate supply, setting or level of service that can safely be provided to You and which cannot be omitted. It will need to be consistent with recognized professional standards of care. In the case of a Hospital stay, also means that safe and adequate care could not be obtained as an Outpatient;
- Cost-effective compared to alternative interventions, including no intervention or the same intervention in an alternative setting. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of Your illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate. For example We will not provide coverage for an Inpatient admission for surgery if the surgery could have been performed on an Outpatient basis or an infusion or injection of a Specialty Drug provided in the Outpatient department of a Hospital if the drug could be provided in a doctor's office or the home setting;
- Not Experimental or Investigational;
- Not primarily for You, Your families, or Your Provider's convenience; and
- Not otherwise an exclusion under this Certificate.

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

The programs of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Member

The Subscriber and enrolled Dependent.

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

A condition or disorder, regardless of etiology, that may be the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the mental disorders section of the most recent version of (a) the international statistical classification of diseases and related health problems; (b) the Diagnostic and Statistical Manual of Mental Disorders (DSM); or (c) the diagnostic classification of mental health and developmental disorders of infancy and early childhood. The phrase also includes Autism Spectrum Disorders, as defined in this Certificate.

Minimum Essential Coverage

The term Minimum Essential Coverage means any of the following: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's healthcare 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 benefits risk pool, or as the Secretary of HHS recognizes.

Out-of-Network

A term for Providers that do not enter into a network contract with Us. However, Out-of-Network Providers are subject to the Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers. Services received from an Out-of-Network Provider are only covered under limited

circumstances.

Out-of-Network Pharmacy

A Pharmacy that does not have an In-Network Pharmacy agreement in effect with or for the benefit of HMO Colorado at the time services are rendered. In most instances, You will be responsible for a larger portion of Your pharmaceutical bill when You go to an Out-of-Network Pharmacy.

Out-of-Pocket Maximum

The most You pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket Maximum does not include Your Premium, amounts over the Maximum Allowed Amount, or charges for healthcare that Your Plan doesn't cover. When the Out-of-Pocket Maximum is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Certificate. Please see the "Schedule of Benefits (Who Pays What)" for details.

Outpatient

A Member who receives services or supplies when not an Inpatient.

Partial Hospitalization Program

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

Pharmacy

A place licensed by State law where You can get Prescription Drugs and other medicines from a licensed pharmacist when You have a Prescription from Your doctor.

Pharmacy and Therapeutics (P&T) Process

Process to make clinically based recommendations that will help You access quality, low cost medicines within Your benefit program. The process includes healthcare professionals such as nurses, pharmacists, and doctors. The committees of the HMO Colorado 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 Prescription Drug List. Our programs may include, but are not limited to, drug utilization programs, Precertification criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives.

Pharmacy Benefits Manager (PBM)

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

HMO Colorado's PBM, in consultation with Us, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Plan

The set of benefits, conditions, exclusions and limitations described in this document.

Precertification

Please see the section "Requesting Approval for Benefits" for details.

Premium

The monthly charge You must pay HMO Colorado to establish and maintain coverage under this Agreement.

Prescription Drug

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.

Prescription Drug List

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 doctors and pharmacists has been reviewed for their quality and cost effectiveness. This Prescription Drug List contains a limited number of Prescription Drugs, and may be different than the formulary for other HMO Colorado products. Generally, it includes select Generic Drugs with limited brand Prescription Drug coverage. This list is subject to periodic review and modification by Us. We may add or delete Prescription Drugs from this Prescription Drug List from time to time. A description of the Prescription Drugs that are listed is available upon request and at www.anthem.com.

Prescription Order (Prescription)

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

Primary Care Physician (“PCP”)

An In-Network Provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, geriatrics or any other In-Network Provider as allowed by Us. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Provider

A professional or Facility licensed by law that gives healthcare 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 Contract. If You have a question about a Provider not described in this Contract please call the number on the back of Your Identification Card.

Qualified Health Plan or QHP

A health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer (QHP Issuer)

A health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual

With respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Referral

A specific recommendation by a Member's PCP that the Member should receive evaluation or treatment from a specific Provider. A recommendation from a Provider is a Referral only to the extent of the specific services approved by the PCP on the written Referral form or by other notification methods prescribed by HMO Colorado for use by PCPs. A general statement by a PCP that a Member should seek a particular type of service or Provider does not constitute a Referral under this Certificate.

Rehabilitative Services

Healthcare services that help a person get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in

a variety of Inpatient and/or Outpatient settings.

Residential Treatment Center

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

1. Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability.
2. A staff with one or more doctors available at all times.
3. Residential treatment that takes place in a structured Facility-based setting, and does not take place outdoors, e.g., wilderness program or therapy.
4. The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
5. A Facility that is designated residential, subacute or intermediate care and may occur in care systems that provide multiple levels of care.
6. A Facility that is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO) or the Council on Accreditation (COA).

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

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Wilderness therapy or programs

Retail Pharmacy

An establishment licensed to dispense Prescription Drugs and other medications (other than Specialty Drugs) through a licensed pharmacist or Home Delivery Pharmacy service upon an authorized healthcare professional's order.

Self-Administered Drugs

Drugs that are administered which do not require a medical professional to administer.

Service Area

The geographic area where this health benefit plan is offered and approved by State regulatory agencies. The Service Area of this plan may be more limited than the HMO Colorado Service Area and may be limited to the county in which You reside at the time of application or enrollment in this health benefit plan. For more information regarding the Service Area for this plan, please contact Member Services at the number on the back of Your Identification Card.

Skilled Nursing Facility

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

Inpatient care and treatment for people who are recovering from an illness or injury;

Care supervised by a doctor;

24 hour per day nursing care supervised by a full-time registered nurse.

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

Specialty Care Physician (Specialist or SCP)

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

Specialty Drugs

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 Pharmacy

A Pharmacy that is designated by Us, other than a Retail Pharmacy or Home Delivery Pharmacy that provides high cost, biotech drugs which are used for the treatment of acute or chronic diseases.

State

Each of the 50 States and the District of Columbia.

Subscriber

The Member who applied for coverage and in whose name this Certificate is issued.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network air ambulance services.

Tax Dependent

Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer

Tax Filer means an individual, or a married couple, who indicates that he, she or they expect:

1. To file an income tax return for the Benefit Year;
2. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
3. That no other taxpayer will be able to claim him, her or them as a Tax Dependent for the Benefit Year; and
4. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapeutic Care

For purposes of the Autism Spectrum Disorders, this type of care is provided by a speech, occupational or physical therapist, or an Autism Services Provider. Therapeutic Care includes speech, occupational, and applied behavior analytic and physical therapies.

Urgent Care

Medical care for an unexpected illness or injury 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 Care Center

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

Utilization Review

A set of formal techniques to monitor or evaluate the clinical necessity, appropriateness, efficacy or efficiency of, healthcare 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 and Our
HMO Colorado

Year and Yearly

A 12 month period.

You and Your

The Member, Subscriber and each covered Dependent.

Get help in your language

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

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

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

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

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

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

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

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

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

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

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

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo
Bee ná ahoot'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áaji' hodíilnih. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

SUBSCRIBER AND PREMIUM INFORMATION

Issued by:
HMO Colorado

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.