Certificate

(Referred to as “Booklet” in the following pages)

Anthem

Anthem Gold PPO 1500/20%/5500 Rx Copay

Outpatient Retail Prescription Drug Copayment Plan

January 1, 2025



Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece en el reverso de su Tarjeta de Identificación.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling Member Services at the number on the back of your Identification Card.

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Section 1. Schedule of Benefits (Who Pays What)

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Please read the "Benefits/Coverage (What is Covered)" section for more details on the Plan's Covered Services. Read the "Limitations/Exclusions (What is Not Covered)" section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. Except for Surprise Billing Claims, when you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the "Member Payment Responsibility" section for more details.

Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider's billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- **Ambulatory patient services,**
- **Emergency services,**
- **Hospitalization,**
- **Maternity and newborn care,**
- **Mental health and substance use disorder services, including behavioral health treatment,**
- **Prescription drugs,**
- **Rehabilitative and Habilitative Services and devices,**
- **Laboratory services,**
- **Preventive and wellness services, and**
- **Chronic disease management and pediatric services, including oral and vision care.**

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any state or federal regulations issued pursuant thereto.

To the extent required by applicable law, Prescription Drug coverage will include at least one (1) 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.

Benefit Period	Calendar Year

Dependent Age Limit	To the end of the Plan year in which the child attains age 26. Please see the "Eligibility" section for further details.

Deductible Type: Embedded	In-Network	Out-of-Network
Per Member	$1,500	$4,500
Per Family – All other Members combined	$3,000	$9,000

Embedded

Per Member - If you, the Subscriber, are the only person covered by this Plan, only the "per Member" amounts apply to you.

Per Family - If you also cover Dependents (other family members) under this Plan, only the "per Family" amounts apply. The "per Family' Deductible can be met by two or more individuals.

The In-Network and Out-of-Network Deductibles are separate and cannot be combined.

When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.

Copayments and Coinsurance are separate from and do not apply to the Deductible.

Coinsurance	In-Network	Out-of-Network
Plan Pays	80%	50%
Member Pays	20%	50%

Reminder: Except for Surprise Billing Claims, your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.

Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.

Out-of-Pocket Limit	In-Network	Out-of-Network
Per Member	$5,500	$16,500
Per Family – All other Members combined	$11,000	$33,000

Embedded:

The per Member Out-of-Pocket Limit applies to each covered family member. Once two or more covered family members' Out-of-Pocket Limit combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that Benefit Period. No one person can contribute more than the Per Member Out-of-Pocket Limit amount.

The Out-of-Pocket Limit includes all Deductibles, Coinsurance, and Copayments you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.

The Out-of-Pocket Limit does not include amounts you pay for the following benefits:

Out-of-Pocket Limit	In-Network	Out-of-Network
• Services listed under “Vision Services for Members Age 19 and Older” • Out-of-Network Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy services. Once the Out-of-Pocket Limit is satisfied, you will not have to pay additional Deductibles, Coinsurance, or Copayments for the rest of the Benefit Period, except for the services listed above. The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.		

Important Notice about Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

The tables below outline the Plan’s Covered Services and the cost share(s) you must pay. In many spots you will see the statement, “Benefits are based on the setting in which Covered Services are received.” In these cases, you should determine where you will receive the service (i.e., in a doctor’s office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor’s office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up “Office and Home Visits.” For services in the outpatient department of a hospital, look up “Outpatient Facility Services.” For services during an inpatient stay, look up “Inpatient Services.”

Benefits	In-Network	Out-of-Network
Abortion Services	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
Acupuncture	See “Office and Home Visits” and “Therapy Services.”	Not covered
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Ground, Air, and Water) Emergency Services For Emergency ambulance services from an Out-of-Network Provider you do not need to pay any more than would have paid for services from an In-Network Provider.	20% Coinsurance after Deductible	
Ambulance Services (Ground, Air, and Water) Non-Emergency Services For Emergency ambulance services from an Out-of-Network Provider you do not need to pay any more than would have paid for services from an In-Network Provider.	20% Coinsurance after Deductible	

Benefits	In-Network	Out-of-Network
Important Note: All scheduled ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through precertification. Please see "How to Access Your Services and Obtain Approval of Benefits" for details. Benefits for non-Emergency ambulance services will be limited to $50,000 per trip if an Out-of-Network Provider is used.		
Autism Services The limits for physical, occupational, and speech therapy will not apply to children with Autism Spectrum Disorders, if part of a Member's Autism Treatment Plan.	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Behavioral Health Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Cardiac Rehabilitation	See "Therapy Services."	
Cellular and Gene Therapy Services • Precertification required	See the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" section later in this Schedule.	
Chemotherapy	See "Therapy Services."	

Benefits	In-Network	Out-of-Network
Chiropractic Care	See “Therapy Services.”	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
Dental Services For Members Through Age 18 Note: To get the In-Network benefit, you must use a participating dental Provider. If you need help finding a participating dental Provider, please call us at the number on the back of your Identification Card.		
• Diagnostic and Preventive Services	No Copayment, Deductible, or Coinsurance	Deductible waived, subject to 30% Coinsurance
• Basic Restorative Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Endodontic Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Periodontal Services	Not covered	Not covered
• Oral Surgery Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Major Restorative Services	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prosthodontic Services	Not covered	Not covered
• Dentally Necessary Orthodontic Care	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Dental Services (All Members / All Ages) (Limited to services for accidental injury, for certain Members requiring hospitalization or general anesthesia, or to prepare the mouth for certain medical treatments.)	Benefits are based on the setting in which Covered Services are received.	
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under “Preventive Care.” Benefits for diabetic education are based on the setting in which Covered Services are received.	20% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
Diagnostic Services (includes testing and treatment of COVID-19, as required under any applicable Federal or State law)		
• Reference Labs	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
• All Other Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis	See “Therapy Services.”	
Durable Medical Equipment (DME), Medical Devices, and Supplies		
• Durable Medical Equipment	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Orthotics	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prosthetics For prosthetic arms and legs, we cover up to the benefits amounts provided by federal laws for Medicare or where needed to meet state insurance laws.	50% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prosthetic Limbs For prosthetic arms and legs, we cover up to the benefits amounts provided by federal laws for Medicare or where needed to meet state insurance laws.	20% Coinsurance no Deductible	50% Coinsurance after Deductible
• Medical and Surgical Supplies	50% Coinsurance after Deductible	50% Coinsurance after Deductible
The cost-shares listed above apply when your Provider submits separate bills for the equipment or supplies.		
Hearing Aids Benefit Maximum for Members under 18 years of age New hearing aids will be a covered service when alterations to your existing hearing aids cannot adequately meet your needs or be repaired.	Initial and replacement hearing aids will be supplied every 5 years, In- and Out-of-Network combined.	
• Wigs Needed After Cancer Treatment	50% Coinsurance after Deductible	50% Coinsurance after Deductible
Wigs Needed After Cancer Treatment Benefit Maximum	One wig per Benefit Period In- and Out-of-Network combined	

Benefits	In-Network	Out-of-Network
The Plan's reimbursement for durable medical equipment, orthotics, prosthetics, devices and supplies, hearing aids, and wigs will be based on the Maximum Allowed Amount for a standard item that is Medically Necessary to meet your needs. If you choose to purchase an item with features that exceed what is Medically Necessary, benefits will be limited to the Maximum Allowed Amount for the standard item, and you will be required to pay any costs that exceed the Maximum Allowed Amount. Please check with your Provider or contact us if you have questions about the Maximum Allowed Amount.		
Emergency Room Services		
Emergency Room		
• Emergency Room Facility Charge	$300 Copayment per visit then 20% Coinsurance after Deductible Copayment waived if admitted	
• Emergency Room Doctor Charge (ER physician, radiologist, anesthesiologist, surgeon)	20% Coinsurance after Deductible	
• Emergency Room Doctor Charge (Mental Health / Substance Use Disorder)	20% Coinsurance after Deductible	
• Other Facility Charges (including diagnostic x-ray and lab services, medical supplies)	20% Coinsurance after Deductible	
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$250 Copayment per day then 20% Coinsurance after Deductible	
For Emergency Services from an Out-of-Network Provider you do not need to pay any more than you would have paid for services from an In-Network Provider. As described in the "Consolidated Appropriations Act of 2021 Notice", for Emergency Services, Out-of-Network Providers may only bill you for any applicable Copayments, Deductible, and Coinsurance and may not bill you for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable and followed the notice and consent process. Please refer to the notice following the "Schedule of Benefits (Who Pays What)" for more details.		
Gender Affirming Health Services	Benefits are based on the setting in which Covered Services are received.	
Habilitative Services	Benefits are based on the setting in which Covered Services are received. See "Inpatient Services" and "Therapy Services" for details on Benefit Maximums.	

Benefits	In-Network	Out-of-Network
Home Health Care		
• Home Health Care Visits from a Home Health Care Agency (including intermittent skilled nursing services)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Home Dialysis	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Home Infusion Therapy / Chemotherapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Specialty Prescription Drugs for Infusion / Injection – other than Chemotherapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Home Health Care Services / Supplies	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Private Duty Nursing (including continuous complex skilled nursing services)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Home Health Care Benefit Maximum	28 hours of visits per week In- and Out-of-Network combined The limit includes Private Duty Nursing given as part of the Home Health Care benefit. The limit does not apply to Home Infusion Therapy or Home Dialysis.	
Home Infusion Therapy	See “Home Health Care.”	
Hospice Care		
• Home Hospice Care	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Bereavement	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Inpatient Hospice	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Outpatient Hospice	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Respite Care	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	Please see the separate summary later in this section.	

Benefits	In-Network	Out-of-Network
Infertility Services	See “Maternity and Reproductive Health Services.”	
Inpatient Services		
Facility Room & Board Charge:		
• Hospital / Acute Care Facility	$500 Copayment per admission then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Skilled Nursing Facility	$500 Copayment per admission then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
Skilled Nursing Facility / Habilitation Services / Rehabilitation Services (Includes services in an Outpatient Day Rehabilitation Program) Benefit Maximum combined	100 days per Benefit Period In- and Out-of-Network combined	
• Rehabilitation	$500 Copayment per admission then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
Inpatient Rehabilitation Services Benefit Maximum	No less than 60 days per Benefit Period In- and Out-of-Network combined	
• Mental Health / Substance Use Disorder Facility	$500 Copayment per admission then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Residential Treatment Center	$500 Copayment per admission then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Ancillary Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Hospital Transfers: If you are transferred between Facilities, only one Copayment will apply. You will not have to pay separate Copayments per Facility.		
Hospital Readmissions: If you are readmitted to the Hospital within 72 hours of your discharge for the same medical diagnosis, you will not have to pay an additional Copayment upon readmission.		
Doctor Services when billed separately from the Facility for:		
• General Medical Care / Evaluation and Management (E&M)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Surgery	20% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Maternity	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Services	$40 Copayment per visit then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
Bariatric Surgery	Benefits are based on the setting in which Covered Services are received.	
Maternity and Reproductive Health Services		
• Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Inpatient Services (Delivery)	See "Inpatient Services."	
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
• Infertility Services	Benefits are based on the setting in which Covered Services are received.	Not covered
Massage Therapy	See "Office and Home Visits" and "Therapy Services."	
Mental Health and Substance Use Disorder Services	Mental Health and Substance Use Disorder Services are covered as required by state and federal law. Please see the rest of this Schedule for the cost shares that apply in each setting.	
Occupational Therapy	See "Therapy Services."	
Office and Home* Visits *Home visits are not the same as Home Health Care. For Home Health Care benefits please see the "Home Health Care" section. If you have an office visit with your PCP or SCP at an Outpatient Facility (e.g., Hospital or Ambulatory Surgery Center), benefits for Covered Services will be paid under the "Outpatient Facility Services" section later in this Schedule. Please refer to that section for details on the cost shares (e.g., Deductibles, Copayments, Coinsurance) that will apply.		
• Primary Care Physician / Provider (PCP) (Including In-Person and/or Virtual Visits)	In-Person Visits: $40 Copayment per visit	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Additional Telehealth / Telemedicine Services from a Primary Care Provider (PCP) (as required by law)	Virtual Visits: $40 Copayment per visit No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
• Mental Health and Substance Use Disorder Provider (Including In-Person and/or Virtual Visits)	In-Person Visits: $40 Copayment per visit Virtual Visits: $40 Copayment per visit	50% Coinsurance after Deductible
• Specialty Care Physician / Provider (SCP) (including In-Person and/or Virtual Visits)	In-Person Visits: $80 Copayment per visit Virtual Visits: $80 Copayment per visit	50% Coinsurance after Deductible
• Additional Telehealth / Telemedicine from a Specialty Care Provider (SCP) (as required by law)	$80 Copayment per visit	50% Coinsurance after Deductible
• Retail Health Clinic Visit	$40 Copayment per visit	50% Coinsurance after Deductible
• Counseling – Includes Family Planning and Nutritional Counseling (Other than Eating Disorders)	$40 Copayment per visit	50% Coinsurance after Deductible
• Nutritional Counseling for Eating Disorders	$40 Copayment per visit	50% Coinsurance after Deductible
• Allergy Testing	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic Lab (other than reference labs)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$250 Copayment per day then 20% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Office Surgery (including anesthesia)	$500 Copayment per visit then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Therapy Services: 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.		
– Chiropractic Care / Osteopathic / Manipulative Therapy (regardless of the Provider type rendering the service)	$40 Copayment per visit	Not covered
– Acupuncture & Massage Therapy	$40 Copayment per visit	Not covered
– Physical Therapy	$40 Copayment per visit	50% Coinsurance after Deductible
– Speech Therapy	$40 Copayment per visit	50% Coinsurance after Deductible
– Occupational Therapy	$40 Copayment per visit	50% Coinsurance after Deductible
– Dialysis	20% Coinsurance after Deductible	50% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
– Cardiac Rehabilitation	$80 Copayment per visit	50% Coinsurance after Deductible
– Pulmonary Therapy	$80 Copayment per visit	50% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.		
• Prescription Drugs Administered in the Office (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Orthotics	See “Durable Medical Equipment (DME), Medical Devices, and Supplies.”	
Outpatient Facility Services		
• Facility Surgery Charge	$500 Copayment per visit then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Facility Surgery Lab	20% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Facility Surgery X-ray	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Ancillary Services	$500 Copayment per visit then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Doctor Surgery Charges	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Facility Charges (for procedure rooms)	$500 Copayment per visit then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Outpatient Facility Services (Partial Hospitalization Program / Intensive Outpatient Program)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Mental Health / Substance Use Disorder Outpatient Facility Provider Services (e.g., Doctor and other professional Providers in a Partial Hospitalization Program / Intensive Outpatient Program)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic Lab	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Diagnostic Tests (EKG, EEG, etc.)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$250 Copayment per day then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Therapy:		
– Chiropractic Care / Osteopathic / Manipulative Therapy (regardless of the Provider type rendering the service)	20% Coinsurance after Deductible	Not covered
– Physical Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
– Speech Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
– Occupational Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
– Radiation / Chemotherapy / Respiratory Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
– Dialysis	20% Coinsurance after Deductible	50% Coinsurance after Deductible
– Cardiac Rehabilitation	20% Coinsurance after Deductible	50% Coinsurance after Deductible
– Pulmonary Therapy	20% Coinsurance after Deductible	50% Coinsurance after Deductible
See “Therapy Services” for details on Benefit Maximums.		
• Prescription Drugs Administered in an Outpatient Facility (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
Physical Therapy	See “Therapy Services.”	
Preventive Care	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
Preventive care from an Out-of-Network Provider is not subject to the Maximum Allowed Amount.		
Preventive Care for Chronic Conditions (per IRS guidelines)		
• Prescription Drugs	Please refer to the “Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits” section.	
• Medical items, equipment and screenings	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible
Please see the “Benefits/Coverage (What is Covered)” section for additional details on IRS guidelines.		
Prosthetics	See “Durable Medical Equipment (DME), Medical Devices, and Supplies.”	
Pulmonary Therapy	See “Therapy Services.”	
Radiation Therapy	See “Therapy Services.”	

Benefits	In-Network	Out-of-Network
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received. See “Inpatient Services” and “Therapy Services” for details on Benefit Maximums.	
Respiratory Therapy	See “Therapy Services.”	
Skilled Nursing Facility	See “Inpatient Services.”	
Speech Therapy	See “Therapy Services.”	
Surgery	Benefits are based on the setting in which Covered Services are received.	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
Benefit Maximum(s):	Benefit Maximum(s) are for In- and Out-of-Network visits combined, and for office and outpatient visits combined.	
• Physical Therapy (Rehabilitative)	20 visits per Benefit Period	
• Physical Therapy (Habilitative)	20 visits per Benefit Period	
• Occupational Therapy (Rehabilitative)	20 visits per Benefit Period	
• Occupational Therapy (Habilitative)	20 visits per Benefit Period	
• Speech Therapy (Rehabilitative)	20 visits per Benefit Period For cleft palate or cleft lip conditions, Medically Necessary speech therapy is not limited, but those visits lower the number of speech therapy visits available to treat other problems.	
• Speech Therapy (Habilitative)	20 visits per Benefit Period	

Benefits	In-Network	Out-of-Network
	For cleft palate or cleft lip conditions, Medically Necessary speech therapy is not limited, but those visits lower the number of speech therapy visits available to treat other problems.	
• Chiropractic Care / Osteopathic / Manipulative Therapy (regardless of the Provider type rendering the service)	20 visits per Benefit Period Limit does not apply to osteopathic therapy	Not covered
• Acupuncture & Massage Therapy	20 visits per Benefit Period	Not covered
• Cardiac Rehabilitation	Unlimited	
• Pulmonary Rehabilitation	Unlimited	
Note: The limits for physical, occupational, speech, and cognitive rehabilitation therapy will not apply if you get that care as part of the Mental Health and Substance Use Disorder benefit.		
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.		
Note: When you get physical, occupational, or speech therapy in the home, the Home Health Care Visit will apply instead of the Therapy Services limits listed above.		
Transplant Services	See “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services.”	
Urgent Care Services (Office & Home* Visits)		
*Home visits are not the same as Home Health Care. For Home Health Care benefits please see the “Home Health Care” section.		
• Urgent Care Visit Charge	$80 Copayment per visit	50% Coinsurance after Deductible
• Allergy Testing	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Allergy Shots / Injections (including allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Shots / Injections (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic Lab (other than reference labs)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Diagnostic X-ray	20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Other Diagnostic Tests (including hearing and EKG)	20% Coinsurance after Deductible	50% Coinsurance after Deductible

Benefits	In-Network	Out-of-Network
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	$250 Copayment per day then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Office Surgery (including anesthesia)	$500 Copayment per visit then 20% Coinsurance after Deductible	50% Coinsurance after Deductible
• Prescription Drugs Administered in the Office (other than allergy serum)	20% Coinsurance after Deductible	50% Coinsurance after Deductible
If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.		
Virtual Visits (from Virtual Care-Only Providers)	Virtual Care-Only Providers through our mobile app and website	Out-of-Network Virtual Care-Only Providers
• Virtual Visits including Primary Care from Virtual Care-Only Providers (Medical Services)	No Copayment, Deductible, or Coinsurance	Please refer to the "Office and Home Visits" section
• Virtual Visits from Virtual Care-Only Providers (Mental Health and Substance Use Disorder Services)	No Copayment, Deductible, or Coinsurance	Please refer to the "Office and Home Visits" section
• Virtual Visits from Virtual Care-Only Providers (Specialty Care Services)	$80 Copayment per visit	Please refer to the "Office and Home Visits" section
If Preventive Care is provided during a Virtual Visit, it will be covered under the "Preventive Care" benefit, as required by law. Please refer to that section for details.		
Vision Services For Members Through Age 18 **Note:** To get the In-Network benefit, you must use a Blue View Vision Provider. Visit our website or call the number on your Identification Card for help in finding a Blue View Vision Provider. Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
• Routine Eye Exam	$0 Copayment	0% Coinsurance not subject to Deductible
Limited to one exam per Benefit Period per Member.		
• Standard Plastic Lenses		
Limited to one set of lenses every other Benefit Period per Member.		
Single Vision	$20 Copayment	$0 Copayment; Reimbursed up to the Plan's Maximum Allowed Amount
Bifocal	$20 Copayment	$0 Copayment; Reimbursed up to the Plan's Maximum Allowed Amount

Benefits	In-Network	Out-of-Network
Trifocal	$20 Copayment	$0 Copayment; Reimbursed up to the Plan's Maximum Allowed Amount
Standard Progressive	$20 Copayment	$0 Copayment; Reimbursed up to the Plan's Maximum Allowed Amount
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	$0 Copayment	$0 Copayment; Reimbursed up to the Plan's Maximum Allowed Amount
Limited to one frame from the Anthem Formulary every other Benefit Period per Member.		
• Contact Lenses		
Elective or non-elective contact lenses from the Anthem Formulary are covered every other Benefit Period per Member.		
– Elective Contact Lenses (Conventional or Disposable)	$0 Copayment	$0 Copayment; Reimbursed up to the Plan's Maximum Allowed Amount
– Non-Elective Contact Lenses	$0 Copayment	$0 Copayment; Reimbursed up to the Plan's Maximum Allowed Amount
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 allowed benefit period.		
Vision Services For Members Age 19 and Older		
Note: To get the In-Network benefit, you must use a Blue View Vision Provider. Visit our website or call the number on your Identification Card for help in finding a Blue View Vision Provider. Out-of-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.		
• Routine Eye Exam	$20 Copayment	Reimbursed up to $30
Limited to one exam per Benefit Period per Member.		
• Standard Plastic Lenses		
Limited to one set of lenses every other Benefit Period.		
Single Vision	$20 Copayment	Reimbursed up to $25
Bifocal	$20 Copayment	Reimbursed up to $40
Trifocal	$20 Copayment	Reimbursed up to $55

Benefits	In-Network	Out-of-Network
Photochromic add-on	$20 Copayment (in addition to lens Copayment)	Not covered
Additional lens options: Factory scratch coating is available at no additional cost In-Network.		
• Frames	Covered up to $130	Reimbursed up to $45
Limited to one frame every other Benefit Period per Member.		
• Contact Lenses		
Elective or non-elective contact lenses are covered once every other Benefit Period per Member.		
Elective Contact Lenses (Conventional or Disposable)	Covered up to $80	Reimbursed up to $60
Non-Elective Contact Lenses	No Copayment, Deductible, or Coinsurance	Reimbursed up to $210
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 allowed benefit period.		
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.	Benefits are based on the setting in which Covered Services are received.	

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services		
Please call our Transplant Department as soon as you think you may need a Covered Procedure to talk about your benefit options. To get the In-Network Level of benefits under your Plan, you must get certain Covered Procedures from an Approved In-Network Provider. Even if a Hospital is an In-Network Provider for other services, it may not be an Approved In-Network Provider for certain Covered Procedures. Please see the “Benefits/Coverage (What is Covered)” section for further details.		
The requirements described below do not apply to the following:		
• Cornea transplants, which are covered as any other surgery; and		
• Any Covered Services related to a Covered Procedure, that you get before or after the Benefit Period.		
Benefits for Covered Services that are not part of the Covered Procedure will be based on the setting in which Covered Services are received. Please see the “Benefits/Coverage (What is Covered)” section for additional details.		
	Approved In-Network Provider	**All Other Providers**
Covered Procedure Benefit Period	The number of days or the applicable case rate / global	Not applicable – There is no unique Benefit Period for

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services		
	time period will vary depending on the type of Covered Procedure and the Approved In-Network Provider agreement. Before and after the Covered Procedure Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending on where the service is performed.	services from All Other Providers.
Inpatient Facility Services • **Precertification required**	$500 Copayment per admission then 20% Coinsurance after Deductible	50% Coinsurance after Deductible. These charges will NOT apply to your Out-of-Pocket Limit.
Inpatient Professional and Ancillary (non-Hospital) Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Note on Hospital Readmissions: If you are readmitted to the Hospital during the Covered Procedure Benefit Period, you will not have to pay an additional Copayment upon readmission.		
Outpatient Facility Services • **Precertification required**	$500 Copayment per Covered Procedure Benefit Period then 20% Coinsurance after Deductible	50% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Outpatient Facility Professional and Ancillary (non-Hospital) Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit
Travel Expenses		
• **Transportation and Lodging Limit**	Covered, as approved by us, up to $10,000 per Benefit Period. In- and Out-of-Network combined	

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services		
Unrelated donor searches from an authorized, licensed registry for bone marrow/stem cell transplants for a Covered Human Organ and Tissue Transplant Procedure	20% Coinsurance after Deductible	50% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
• **Donor Search Limit**	Covered, as approved by us, up to $30,000 per transplant. In- and Out-of-Network combined This limitation does not apply to living organ transplants in which case donor costs will be covered to the extent required by applicable law.	
Live Donor Health Services		
• **Inpatient Facility Services**	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
• **Outpatient Facility Services**	No Copayment, Deductible, or Coinsurance	50% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
• **Donor Health Service Limit**	For Human Organ and Tissue Transplants, Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement. This limitation does not apply to living organ transplants in which case donor costs will be covered to the extent required by applicable law.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
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. Otherwise, each Prescription Drug will be subject to a cost share (e.g., Copayment/Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount. Note: A Prescription contraceptive provided by an In-Network Pharmacy can be dispensed to a Member for a 12-month supply. The per Member per prescription cost share will not exceed $20 for any 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 any Prescription Drug that contains insulin and is used to treat diabetes, will not exceed a total, across all such Prescription Drugs, of $100 per 30-day supply or $300 per 90-day supply, when obtained In-Network. Deductible does not apply. **Day Supply Limitations –** Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)	30 days **Note:** A 90-day supply is available at Maintenance Pharmacies. When you get a 90-day supply at a Maintenance Pharmacy, three (3) Retail Pharmacy Copayments (one for each 30-day period) will apply. When you get a 30-day supply, one Copayment per Prescription Order will apply.	
Home Delivery (Mail Order) Pharmacy	90 days	
Specialty Pharmacy	30 days* *See additional information in the “Specialty Drug Copayments / Coinsurance” section below.	
Note: Tier 1 Prescription Drugs that we are required to cover by federal law under the “Preventive Care” benefit will be covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.		
Retail Pharmacy Copayments / Coinsurance:		
Tier 1a Prescription Drugs	$0 Copayment per Prescription Drug	50% Coinsurance
Tier 1b Prescription Drugs	$10 Copayment per Prescription Drug	50% Coinsurance
Tier 2 Prescription Drugs	$60 Copayment per Prescription Drug	50% Coinsurance
Tier 3 Prescription Drugs	$125 Copayment per Prescription Drug	50% Coinsurance
Tier 4 Prescription Drugs	$458 Copayment per Prescription Drug	50% Coinsurance

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
Home Delivery Pharmacy Copayments / Coinsurance:		
For a Home Delivery (Mail Order) Prescription Drug, the per Member per prescription cost share will not exceed $20 for any 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 any Prescription Drug that contains insulin and is used to treat diabetes, will not exceed a total, across all such Prescription Drugs, of $100 per 30 day supply or $300 per 90 day supply, when obtained In-Network. Deductible does not apply.		
Tier 1a Prescription Drugs	$0 Copayment per Prescription Drug	Not covered
Tier 1b Prescription Drugs	$25 Copayment per Prescription Drug	Not covered
Tier 2 Prescription Drugs	$180 Copayment per Prescription Drug	Not covered
Tier 3 Prescription Drugs	$375 Copayment per Prescription Drug	Not covered
Tier 4 Prescription Drugs	$458 Copayment per Prescription Drug	Not covered
Specialty Drug Copayments / Coinsurance:		
Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see “Specialty Pharmacy” in the section “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for further details. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy.		
Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.		
Note: Your cost share will not exceed $60 for a two-pack of Prescription epinephrine auto-injectors. If you have a high Deductible plan, you must first meet the Deductible before this limit applies.		

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 as 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 received 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, Out-of-Network cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care 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. If you continue to receive services from the Out-of-Network Provider after you are stabilized, you will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed 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 an In-Network Facility

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your Out-of-Pocket costs will be limited to amounts that would apply if Covered Service has been furnished by an In-Network Provider. However, if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges claims will be paid at the Out-of-Network benefit level. This means you will be responsible for Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This Notice and Consent process described below does not apply to Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility. Your Out-of-Pocket costs for claims for Covered Ancillary Services furnished by an Out-of-Network Provider at an In-Network Facility will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Provider. 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.

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

- By obtaining your written consent not later than 72 hours prior to the delivery of services, or
- 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.

Out-of-Network Air Ambulance Services

When you receive Covered Services from an Out-of-Network Air Ambulance Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Service had been furnished by an In-Network Air Ambulance Provider.

How Cost-Shares are Calculated

Your cost shares for Surprise Billing Claims will be calculated based on the Recognized Amount. 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, or for Covered Services provided by an Out-of-Network Air Ambulance Service Provider, will be applied to your In-Network Out-of-Pocket Limit.

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 the “Appeals and Complaints” section of this Benefit Book.

Provider Directories

We are required to confirm the list of In-Network Providers in our Provider Directory every 90 days. If you can show that you received inaccurate information from us that a Provider was In-Network on a particular claim, then you will only be liable for In-Network cost shares (i.e., Copayment, Deductibles, and/or Coinsurance) for that claim. Your In-Network cost-shares will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

We provide the following information on our website (i.e., 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 our website or by calling Member Services at the phone number on the back of your ID Card:

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

In addition, we will provide access through our website to the following information:

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

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician / Provider

We generally allow the designation of a Primary Care Physician / Provider (PCP). You have the right to designate any PCP who participates in 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 (ObGyn) Care

You do not need referral or authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Additional Federal Notices

Statement of Rights under the Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Statement of Rights under the Women's Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan. (See the "Schedule of Benefits (Who Pays What)" for details.) If you would like more information on WHCRA benefits, call us at the number on the back of your Identification Card.

Coverage for a Child Due to a Qualified Medical Support Order ("QMCSO")

If you or your spouse are required, due to a QMCSO, to provide coverage for your child(ren), you may ask the Group to provide you, without charge, a written statement outlining the procedures for getting coverage for such child(ren).

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on Mental Health and Substance Use Disorder benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering Mental Health and Substance Use Disorder benefits cannot set day/visit limits on Mental Health and Substance Use Disorder benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on Mental Health and Substance Use Disorder benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on Mental Health and Substance Use Disorder benefits that are more restrictive than the predominant Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to substantially all medical and surgical benefits in the same classification. Medical Necessity criteria are available upon request.

Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing

towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program).

The Subscriber or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

To request special enrollment or obtain more information, call us at the Member Services telephone number on your Identification Card, or contact the Group.

Statement of ERISA Rights

Please note: This section applies to employer sponsored plans **other than** Church employer groups and government groups. If you have questions about whether this Plan is governed by ERISA, please contact the Plan Administrator (the Group).

The Employee Retirement Income Security Act of 1974 (ERISA) entitles you, as a Member of the Group under this Contract, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions;
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for you and other employees, ERISA imposes duties on the people responsible for the operation of your employee benefit plan. The people who operate your plan are called plan fiduciaries. They must handle your plan prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your right under ERISA. If your claim for welfare benefits is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claims reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone

directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Notices Required by State Law

Cancer Screenings

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

Pap Tests

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

Mammogram Screenings

All Plans provide coverage under the preventive care benefits for routine screening or diagnostic mammogram regardless of age 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 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 based on the Plan's provisions for preventive care.

No-Adult Dental Services

This policy does not provide any dental benefits to individuals age nineteen (19) or older, except as specifically provided in the benefit booklet. This policy is being offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. If you want adult dental benefits, you will need to buy a plan that has adult dental benefits. Except as stated in the benefit booklet, this plan will not pay for any adult dental care, so you will have to pay the full price of any care you receive.

NOTICE OF PROTECTION PROVIDED BY LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

This notice provides a brief summary of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- **Life Insurance**

  $300,000 in death benefits

  $100,000 in cash surrender or withdrawal values

- **Health Insurance**

  $500,000 in hospital, medical and surgical insurance benefits

  $300,000 in disability insurance benefits

  $300,000 in long-term care insurance benefits

  $100,000 in other types of health insurance benefits

- **Annuities**

  $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website www.colifega.org, email jwrhodes@colifega.org or contact:

Colorado Life and Health Insurance Protection Association 201 Robert S. Kerr Ave. Suite 600 Oklahoma City, OK 73102 1-800-337-7796	*Colorado Division of Insurance* 1560 Broadway, Suite 850 Denver, CO 80202 (303) 894-7499

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.

Section 2. Title Page (Cover Page)

Anthem Blue Cross and Blue Shield

Anthem Gold PPO 1500/20%/5500 Rx Copay

Outpatient Retail Prescription Drug Copayment Plan

Section 3. Contact Us

Welcome to Anthem!

We are pleased that you have become a Member of our health insurance Plan. We want to make sure that our services are easy to use. We've designed this Booklet to give a clear description of your benefits, as well as our rules and procedures.

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

Your Group has agreed to be subject to the terms and conditions of Anthem Provider agreements which may include pre-service review and utilization management requirements, coordination of benefits, timely filing limits, and other requirements to administer the benefits under this Plan.

This Booklet replaces any Booklet issued to you in the past. The coverage described is based upon the terms of the Group Contract issued to your Group, and the Plan that your Group chose for you. This Booklet forms the entire legal contract under which Covered Services are available. In addition, the Group has a Group Contract and Group Application which includes terms that apply to this coverage.

Many words used in the Booklet have special meanings (e.g., Group, 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 Booklet you will also see references to "we," "us," "our," "you," and "your." The words "we," "us," and "our" mean Anthem Blue Cross and Blue Shield or any of our subsidiaries, affiliates, subcontractors, or designees. 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 Services at the number on the back of your Identification Card. You can also contact us at:

800-234-0111
Anthem Blue Cross and Blue Shield
700 Broadway
Denver, CO 80273

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!

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem 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. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.



Matt Pickett
President Colorado Commercial Business
Anthem Blue Cross and Blue Shield

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 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 health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your Plan.
- Work with your Doctors and other healthcare professionals to make choices about your health care.
- Be treated with respect and dignity.
- Expect us to keep your personal health information private by following our privacy policies, and state and federal laws.
- Receive information you need to fully engage with your health Plan and share your feedback. This includes:
  - Our company and services.
  - Our network of Doctors and other health care 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 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 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 / Provider, also called a PCP, if your 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 health care professionals if you don’t understand the type of care and your actions that they’re 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 anthem.com and select 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 governed by the Booklet and not by this Member Rights and Responsibilities statement.

A copy of the Member Rights and Responsibilities statement can also be found on our website FAQs. To access, go to www.anthem.com. and select Member Support. Under the Support column, select FAQ and your state, then the “Laws and Rights That Protect You” category. Then click on the “What are my rights as a member?” question.

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

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Section 5. Eligibility

In this section you will find information on who is eligible for coverage under this Plan and when Members can be added to your coverage. Eligibility requirements are described in general terms below. For more specific information, please see your Human Resources or Benefits Department.

Who is Eligible for Coverage

The Subscriber

To be eligible to enroll as a Subscriber, the individual must:

- Be an employee of the Group, and
- Be entitled to participate in the benefit Plan arranged by the Group, and
- Have satisfied any probationary or waiting period established by the Group and perform the duties of your principal occupation for the Group.

Dependents

To be eligible to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Group, and be one of the following:

- The Subscribers spouse, including the partner to a civil union as recognized by Colorado law. For information on spousal eligibility, please contact the Group.
- Common-law spouse. A Common-Law Marriage Affidavit is needed to enroll a common-law spouse. All references to spouse in this Booklet include a common-law spouse.

  A common law spouse is an eligible Dependent who has a valid common-law marriage in Colorado. This is the same as any other marriage and can only end by death or divorce.
- Designated beneficiary. Your Group may have decided to offer benefits under this plan to designated beneficiaries. Check with your Group to learn more. If they are recognized by the Group, all references to spouse in this Booklet include a designated beneficiary. A Recorded Designated Beneficiary Agreement will need to be provided. A designated beneficiary is not eligible for COBRA under this Booklet.

  A designated beneficiary is an agreement entered into by two people for the purpose of making each a beneficiary of the other and which has been recorded with the county clerk and recorder in the county in which one of the person lives. The agreement is based on the Colorado Designated Beneficiary Act.
- Domestic partner. Domestic Partner, or Domestic Partnership means a person of the same sex who is the Subscriber's sole Domestic Partner and has been for 12 months or more; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by state law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

  For purposes of this Plan, a Domestic Partner or partner to a recognized civil union shall be treated the same as a spouse, and that partner's child, adopted child, or child for whom he or she has legal guardianship shall be treated the same as any other child. The coverage of a Domestic Partner, civil union partner, or the child of such partner ends on the date of dissolution of the Domestic Partnership or civil union.

  While this Booklet will recognize and provide benefits for a Member who is a spouse or child in connection with a Domestic Partner or recognized civil union relationship, not every federal or state law that applies to a Member who is a spouse or child under this Plan will also apply to a Domestic Partner or a partner under a civil union. This includes but is not limited to, COBRA and FMLA.

  We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

- The Subscriber's or the Subscriber's spouse's children, including natural children, stepchildren, newborn and legally adopted children, and children who the Group has determined are covered under a Qualified Medical Child Support Order as defined by ERISA or any applicable state law.
- Children, including grandchildren, for whom the Subscriber or the Subscriber's spouse is a permanent legal guardian or as otherwise required by law.

  All enrolled eligible children will continue to be covered until the age limit listed in the "Schedule of Benefits (Who Pays What)". Coverage may be continued past the age limit in the following circumstances:

  - Eligibility will be continued past the age limit only for those Dependents who are unmarried and medically certified as mentally or physical impaired and are dependent upon the parent Subscriber. We may ask for a physician to certify the Dependent's eligibility. We must be informed of the Dependent's eligibility for continuation of coverage within 30 days after the date Dependent would normally become ineligible. You must notify us if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

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

  To obtain coverage for children, we may require you to give us a copy of any legal documents awarding permanent guardianship of such child(ren) to you.

Your group may have limited or excluded the eligibility of certain Dependent types and so not all Dependents listed in this Plan may be entitled to enroll. For more specific information, please see your Human Resources or Benefits Department.

Types of Coverage

Your Group offers some or all of the enrollment options listed below. After reviewing the available options, you may choose the option that best meets your needs. The options may include:

- Subscriber only (also referred to as single coverage),
- Subscriber and spouse; or Domestic Partner,
- Subscriber and one child,
- Subscriber and child(ren),
- Subscriber and family.

When You Can Enroll

Initial Enrollment

The Group will offer an initial enrollment period to new Subscribers and their Dependents when the Subscriber is first eligible for coverage. Coverage will be effective based on the waiting period chosen by the Group and will not exceed 90 days.

If you did not enroll yourself and/or your Dependents during the initial enrollment period you will only be able to enroll during an Open Enrollment period or during a Special Enrollment period, as described below.

Open Enrollment

Open Enrollment refers to a period of time, usually 60 days, during which eligible Subscribers and Dependents can apply for or change coverage. Open Enrollment occurs only once per year. The Group will notify you when Open Enrollment is available.

Special Enrollment Periods

If a Subscriber or Dependent does not apply for coverage when they were first eligible, they may be able to join the Plan prior to Open Enrollment if they qualify for Special Enrollment. Except as noted otherwise below, the Subscriber or Dependent must request Special Enrollment within 31 days of a qualifying event.

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

Special Enrollment is available for eligible individuals who:

- Lost eligibility under a prior health plan for reasons other than non-payment of premium or due to fraud or intentional misrepresentation of a material fact,
- Lost coverage due to death of a covered employee; the termination or reduction in number of hours of the covered employee's employment, regardless of eligibility for COBRA or state continuation coverage; involuntary termination of coverage; lost eligibility under the Colorado Medical Assistance Act or the Children's Basic Health Plan; or the covered employee becoming eligible for benefits under Title XVIII of the Federal Social Security Act, as amended,
- Lost coverage under a health benefit plan due to the divorce or legal separation of the covered employee from the covered employee's spouse or partner in civil union, or due to the termination of a recognized domestic partnership,
- Is now eligible for coverage due to marriage (including a civil union where recognized in the state where the Subscriber resides), birth, adoption, placement for adoption, placement in foster care, by entering into a Designated Beneficiary Agreement, or pursuant to a QMCSO or other court or administrative order mandating that the individual be covered,
- Exhausted COBRA or state continuation benefits or stopped receiving group contributions toward the cost of the prior health plan, or
- Lost employer contributions towards the cost of the other coverage.

Important Notes about Special Enrollment:

- Members who enroll during Special Enrollment are **not** considered Late Enrollees.
- Individuals must request coverage within 31 days of a qualifying event (i.e., marriage, exhaustion of COBRA, etc.).

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Medicaid and Children's Health Insurance Program Special Enrollment

Eligible Subscribers and Dependents may also enroll under two additional circumstances:

- The Subscriber's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- The Subscriber or Dependent becomes eligible for a subsidy (state premium assistance program)

The Subscriber or Dependent must request Special Enrollment within 60 days of the above events.

Late Enrollees

If the Subscriber does not enroll themselves and/or their Dependents when first eligible or during a Special Enrollment period, they will not be eligible to enroll until the next Open Enrollment Period.

Members Covered Under the Group's Prior Plan

Members who were previously enrolled under another plan offered by the Group that is being replaced by this Plan are eligible for coverage on the Effective Date of this coverage.

Enrolling Dependent Children

Newborn Children

Newborn children are covered automatically from the moment of birth. Following the birth of a child, you should submit an application / change form to the Group within 31, but no more than 60, days to add the newborn to your Plan. During the first 31 days after birth, a newborn child will be covered for Medically Necessary care. This includes well childcare and treatment of medically diagnosed congenital defects and birth abnormalities. This is regardless of the limitations and exclusions applicable to other conditions or procedures of this Booklet.

Even if no additional Premium is required, you should still submit an application / change form to the Group to add the newborn to your Plan, to make sure we have accurate records and are able to cover your claims.

Adopted Children

A child will be considered adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The placement begins when you assume or retain a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates at the time such legal obligation terminates. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Your Dependent's Effective Date will be the date of the adoption or placement for adoption if you send us the completed application / change form within 31 days of the event.

Adding a Child due to Award of Legal Custody or Guardianship

If you or your spouse is awarded permanent legal custody or permanent guardianship for a child, an application must be submitted within 31 days of the date legal custody or guardianship is awarded by the court. Coverage will be effective on the date the court granted legal custody or guardianship.

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

Qualified Medical Child Support Order

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state or federal law, to enroll your child in this Plan, we will permit the child to enroll at any time without regard to any Open Enrollment limits and will provide the benefits of this Plan according to the applicable requirements of such order. However, a child's coverage will not extend beyond any Dependent Age Limit listed in the "Schedule of Benefits (Who Pays What)".

Updating Coverage and/or Removing Dependents

You are required to notify the Group of any changes that affect your eligibility or the eligibility of your Dependents for this Plan. When any of the following occurs, contact the Group, and complete the appropriate forms:

- Changes in address.
- Marriage or divorce or entering into or terminating a recognized civil union or domestic partnership.
- Death of an enrolled family member (a different type of coverage may be necessary).
- Enrollment in another health plan or in Medicare.

- Eligibility for Medicare.
- Dependent child reaching the Dependent Age Limit (see “Termination/Nonrenewal/Continuation”).
- Enrolled Dependent child either becomes totally or permanently disabled or is no longer disabled.

Failure to notify us of individuals no longer eligible for services will not obligate us to cover such services, even if Premium is received for those individuals. All notifications must be in writing and on approved forms.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

Statements and Forms

All Members must complete and submit applications or other forms or statements that we may reasonably request.

Any rights to benefits under this Plan are subject to the condition that all such information is true, correct, and complete. Any intentional material misrepresentation by you may result in termination of coverage as provided in the "Termination/Nonrenewal/Continuation" section. We will not use a statement made by you to void or reduce your coverage after that coverage has been in effect for two years, unless such statement is contained in a written instrument signed by you making such statement and a copy of that instrument is or has been given to you or your beneficiary.

Section 6. How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)

Introduction

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

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

In-Network Services

When you use an In-Network Provider or get care as part of an Authorized Service, Covered Services will be covered at the In-Network level.

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, your cost share for Covered Services will be based on the In-Network level.

Regardless of Medical Necessity, benefits will be denied for care that is not a Covered Service. We have final authority to decide the Medical Necessity of the service.

Selecting a Primary Care Physician

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. While you are required to select a PCP, you are not required to visit the selected PCP and you are not required to get a Referral for Specialist visits.

PCPs include internists, family/general practitioners, pediatricians, qualified certified nurse practitioners, or other qualified primary care providers, as required by law. Each member of a family may select a different Primary Care Physician; 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 Anthem Member.
- Have your Member Identification Card handy. The Doctor’s office may ask you for your group or Member ID number.

- Tell them the reason for your visit.

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

If you need to see a Specialist, you can visit any In-Network Specialist including a behavioral health Provider. You do not have to get a Referral.

In-Network Provider Services

For services from In-Network Providers:

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

We do not guarantee that an In-Network Provider is available for all services and supplies covered under your PPO plan. For some services and supplies we may not have arrangements with In-Network Providers.

Please read the “Member Payment Responsibility” section for additional information on Authorized Services.

After Hours Care

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

Out-of-Network Services

When you do not use an In-Network Provider or get care as part of an Authorized Service, Covered Services are covered at the Out-of-Network level, unless otherwise indicated in this Booklet.

For services from an Out-of-Network Provider:

- The Out-of-Network Provider can charge you the difference between their bill and the Plan’s Maximum Allowed Amount plus any Deductible and/or Coinsurance/Copayments unless your claim involves a Surprise Billing Claim,
- You may have higher cost sharing amounts (i.e., Deductibles, Coinsurance, and/or Copayments) unless your claim involves a Surprise Billing Claim,
- You will have to pay for services that are not Medically Necessary,
- You will have to pay for non-Covered Services,
- You may have to file claims, and
- You must make sure any necessary Precertification is done. (Please see this section for more details.)

Some services, supplies or prescriptions are not Covered Services when you get them from an Out-of-Network Provider. See the “Schedule of Benefits (Who Pays What)” for more information. For those Covered Services that are covered when received from an Out-of-Network Provider; you may have to pay more.

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

Surprise Billing Claims

Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the beginning of this Booklet. Please refer to the section for further details.

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.

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.
- 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. Member Services can help you determine the Provider's name, address, telephone number, professional qualifications, specialty, medical school attended, and board certifications.
- Check with your Doctor or Provider.

Please note that not all In-Network Providers offer all services. For example, some Hospital-based labs are not part of our Reference Lab Network. In those cases, you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Member Services before you get services for more information.

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.

Continuity of Care

If your In-Network Provider leaves our network for any reason other than termination for cause, retirement or death, or if coverage under this Plan ends because your Group's Contract ends, or because your Group changes plans, and you are in active treatment, you may be able to continue seeing that Provider for a limited period of time and still get In-Network benefits. "Active treatment" includes:

1) An ongoing course of treatment for a life-threatening condition, including a chronic illness or condition. A chronic illness or condition is a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time,
2) An ongoing course of treatment for a serious acute condition, (examples include chemotherapy, radiation therapy and post-operative visits),
3) An ongoing course of treatment for pregnancy and through the postpartum period, or
4) A scheduled non-elective surgery from the Provider, including receipt of postoperative care from such Provider or Facility with respect to such a surgery, or
5) An ongoing course of treatment for a health condition for which the Physician or health care Provider attests that discontinuing care by the current Physician or Provider would worsen your condition or interfere with anticipated outcomes, or

6) Continuing care benefits for Members undergoing a course of institutional or Inpatient care from the Provider or Facility and/or determined to be terminally ill and is receiving treatment for such illness from such Provider or Facility.

An “ongoing course of treatment” includes treatments for Mental Health and Substance Use 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 as allowed by law. If you wish to continue seeing the same Provider, you or your Doctor should contact Member Services for details. Any decision by us regarding a request for Continuity of Care is subject to the appeals process.

Crediting Prior Plan Coverage

If you were covered by the Group’s prior carrier / plan within 31 days before the Group’s coverage became effective with us, then you will get credit for any accrued Deductible and, if applicable and approved by us, Out of Pocket amounts for claims incurred within 90 days of the effective date of this Plan. This does not apply to claims incurred prior to the current Benefit Period, or to people who were not covered by the prior carrier or plan on the day before the Group’s coverage with us began, or to people who join the Group later.

If your Group moves from one of our plans to another, (for example, changes its coverage from HMO to PPO), and you were covered by the other product immediately before enrolling in this product with no break in coverage, then you may get credit for any accrued Deductible and Out of Pocket amounts, if applicable and approved by us. Any maximums, when applicable, will be carried over and charged against the maximums under this Plan.

If your Group offers more than one of our products, and you change from one product to another with no break in coverage, you will get credit for any accrued Deductible and, if applicable, Out of Pocket amounts and any maximums will be carried over and charged against maximums under this Plan.

If your Group offers coverage through other products or carriers in addition to ours, and you change products or carriers to enroll in this product with no break in coverage, you will get credit for any accrued Deductible, Out of Pocket, and any maximums under this Plan.

This Section Does Not Apply To You If:

- Your Group moves to this Plan at the beginning of a Benefit Period,
- You change from one of our individual policies to a group plan,
- You change employers, or
- You are a new Member of the Group who joins the Group after the Group's initial enrollment with us.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, we participate in a program called "BlueCard", which provides services to you when you are outside our Service Area. For more details on this program, please see “Inter-Plan Arrangements” in the “Claims Procedure (How to File a Claims)” section.

Identification Card

We will give an Identification Card to each Member enrolled in the Plan. When you get care, you must show your Identification Card. Only a Member who has paid the Premiums for this Plan has the right to services or benefits under this Booklet. If anyone gets services or benefits to which they are not entitled to under the terms of this Booklet, he/she must pay for the actual cost of the services.

Getting Approval for Benefits

Your Plan includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Booklet. Utilization Review aids the

delivery of cost-effective health care 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 reviewed, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens, the service can be requested again in another place and will be reviewed again for Medical Necessity. At times a different 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 approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free-standing imaging center, infusion center, Ambulatory Surgery Center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. Anthem may decide that a treatment that was asked for is not Medically Necessary if clinically equivalent treatment that is more cost effective is available and appropriate. "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 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, we may consider on the date you get service:

- You must be eligible for benefits,
- Premium must be paid for the time period that services are given,
- The service or supply must be the same as was precertified,
- The service or supply must be for the same condition and setting that was precertified, and
- 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 Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental / Investigational as those terms are defined in this Booklet.

  For emergency services, Precertification is not required. For admissions following Emergency Care, you, your authorized representative, or Doctor must tell us of the admission as soon as possible. For childbirth admissions, Precertification is not needed unless the admission lasts beyond the first 48 hours for a vaginal delivery or 96 hours for a cesarean delivery, or if the baby is not sent home at the same time as the mother.

- **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 on an urgent or expedited timeframe when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed 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 determination that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a 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 / Provider 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/ Non-Participating	Member	• You must get Precertification when required. (Call Member Services.) • You 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 to not be Medically Necessary.

Provider Network Status	Responsibility to Get Precertification	Comments
BlueCard Provider	Member **(Except for Inpatient Admissions)**	• You must get Precertification when required. (Call Member Services.) • You 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 to not be Medically Necessary. • **BlueCard Providers must obtain Precertification for all Inpatient Admissions.**
NOTE: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative or Doctor must tell us of the admission as soon as possible.		

How Decisions are Made

We 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 Contract 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
Expedited Pre-service Review	2 business days or 72 hours, whichever is less, from the receipt of request
Non-expedited Pre-service Review	5 business days from the receipt of the request
Expedited Continued Stay / Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request

Type of Review	Timeframe Requirement for Decision and Notification
Expedited Continued Stay / Concurrent Review when: – request is received less than 24 hours before the end of the previous authorization; – no previous authorization exists	The request for Pre-service Review may be rejected 2 business days or 72 hours, whichever is less, from the receipt of the request
Non-expedited Continued Stay / Concurrent Review for ongoing outpatient treatment	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

Anthem may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) and/or offer an alternate benefit if in our sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

We may also select certain qualifying Providers to take part in a program or a Provider agreement 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 Anthem exempts a process, Provider or Claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Member. Anthem may stop or change any such exemption with or without advance notice.

You may find out whether a Provider is taking part in certain programs or a Provider agreement by checking your on-line Provider Directory, 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 management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to this Plan's Members.

Health Plan Individual Case Management

Our health plan individual case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs

coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

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

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and teamwork with you and/or your chosen authorized 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 decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of you and Anthem and you or your authorized representative agree to the alternate or extended benefit in writing. 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 authorized representative in writing.

Section 7. Benefits/Coverage (What is Covered)

This section describes the Covered Services available under your Plan. Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity requirements. Please read the “Schedule of Benefits (Who Pays What)" for details on the amounts you must pay for Covered Services and for details on any Benefit Maximums. Also be sure to read "How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)" for more information on your Plan’s rules. Read the “Limitations/Exclusions (What is Not Covered)” section for important details on Excluded Services.

Your benefits are described below. 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 “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 of Covered Services can be received in several settings, including a Doctor’s office or your home, an Urgent Care Facility, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where and from whom you choose to get Covered Services, and this can result in a change in the amount you need to pay. Please see the “Schedule of Benefits (Who Pays What)” for more details.

Acupuncture

Please see “Therapy Services” later in this section.

Allergy Services

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

Ambulance Services

Medically Necessary ambulance services are a Covered Service 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, water, fixed wing, and rotary wing air transportation.

And one or more of the following are met:

- For ground ambulance, you are taken:
  - From your home, the scene of an accident or medical Emergency to a Hospital.
  - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital.
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.
- For air or water ambulance, you are taken:
  - From the scene of an accident or medical Emergency to a Hospital.
  - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to an In-Network Hospital.
  - Between a Hospital and an approved Facility.

Ambulance services are subject to Medical Necessity reviews by us. Emergency ground ambulance services do not require Precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. For Emergency ambulance services performed by an Out-of-

Network Provider you do not need to pay any more than would have been paid for services from an In-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by us. When using an air ambulance for non-Emergency transportation, we reserve the right to select the air ambulance Provider. If you do not use the air ambulance Provider we select, no benefits will be available. Please see the "Schedule of Benefits (Who Pays What)" for the maximum benefit.

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

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

Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor are not a Covered Service.

Other non-covered ambulance services include, but are not limited to, trips to:

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

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if you are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility or a rehabilitation facility), or if you are taken to a Physician's office or your home.

Hospital to Hospital Transport

If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, you must be taken to the closest Hospital that can treat you. **Coverage is not available for air ambulance transfers simply because you, your family, or your Provider prefers a specific Hospital or Physician.**

Autism Services

Covered Services are provided for the assessment, diagnosis, and treatment of Autism Spectrum Disorders (ASD). 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 set forth 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,
- 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.

Visit limits for physical, occupational, and speech therapy will not apply to Medically Necessary therapies to treat Autism Spectrum Disorders, if part of a Member's Autism Treatment Plan.

Coverage of Autism Spectrum Disorders in this 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 review under the "How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)" section.

Behavioral Health Services

Please see "Mental Health and Substance Use Disorder Services" later in this section.

Cardiac Rehabilitation

Please see "Therapy Services" later in this section.

Cellular and Gene Therapy Services

Your Plan includes benefits for certain cellular and gene therapy services when we approve the benefits in advance through Precertification. See the section "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" for additional details.

Chemotherapy

Please see "Therapy Services" later in this section.

Chiropractic Care

Please see "Therapy Services" later in this section.

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 Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1)

to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

   i. The Department of Veterans Affairs.

   ii. The Department of Defense.

   iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
3. Studies or investigations done for drug trials, which are exempt from the investigational new drug application.

Your Plan may require you to use an In-Network Provider to maximize your benefits.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by this Plan.

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

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service;

ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;

iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or

iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services

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.

Dental Providers

Every plan has a network of dentists to choose from. You can go to any dentist, whether they are in your network or not. But you will almost always pay less for the same level of care if you see a dentist in your network. Also, dentists in your network will send claims for care directly to us. When you go out of network, you may have to pay up front — then you would submit claims to us for reimbursement.

For help finding a dentist in your network, log in to www.anthem.com and go to Find a Doctor. When it asks for the type of doctor, choose dentist. You can also call the Member Services number on your dental Identification Card for help.

Pediatric Dental Covered Services

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 plan. See the "Schedule of Benefits (Who Pays What)" for any applicable Deductible, Coinsurance, Copayment, or other benefit limitations.

Diagnostic and Preventive Services

Oral Exams. Two oral exams are covered 2 times per 12 months.

Radiographs (x-rays)

- Full mouth x-rays (complete series) – 1 time per 60 months and includes bitewings.
- Periapicals.
- Bitewings – 1 series per 12-month period, but not covered in the same period as a full mouth/panoramic x-ray.
- Panoramic film – 1 time per 60 months.

Dental Cleaning (prophylaxis). Procedure to remove plaque, tartar (calculus), and stain from teeth. Covered 1 time per 12 months.

Fluoride Treatment (topical application or fluoride varnish). Covered 2 times per 12 months.

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/ or there are no restorations. Coverage does not include prep or conditioning of tooth or any other procedure associated with sealant application. Repair or replacement of sealant on any tooth will not be covered within 36 months of application. Such repair or replacement given by the same dentist that applied the sealant is considered included in the allowance for initial placement of sealant.

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

Emergency Treatment (also called palliative treatment). Covered for the temporary relief of pain or infection.

Basic Restorative Services

Fillings (restorations). Covered 1 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.

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're responsible to pay for any amount over the Maximum Allowed Amount, plus any applicable Deductible and Coinsurance.

Recement Crown.

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

Sedative Filling.

Pin Retention. Per tooth, in addition to restoration.

Oral Surgery Services

Basic Extractions

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

Complex Surgical Extractions. Surgical removal of 3rd molars is covered when symptoms of oral pathology exist. 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.

Endodontic Services

Endodontic Therapy

- **Therapeutic Pulpotomy.** Covered for primary teeth only.
- **Root Canal Therapy.** Covered for permanent teeth only.

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 about 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.

Note: For adult orthodontic services for cleft lip and cleft palate conditions, see the Dental Services (All Members / All Ages) description.

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 which interferes with the 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, or
- On an objective professionally orthodontic severity index, your condition scores consistent with needing 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 limited 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 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 Plan.

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 your coverage under this Plan ends.

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

What Orthodontic Care Does NOT Include, unless for Medically Necessary care for cleft palate and cleft lip conditions as provided by this Booklet. 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 Plan.
- Any provisional splinting, temporary procedures, or interim stabilization of the teeth.

Dental Services (All Members / All Ages)

Preparing the Mouth for Medical Treatments

Your Plan includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental x-rays
- Extractions, including surgical extractions
- Anesthesia

Treatment of Accidental Injury

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

Cleft Palate and Cleft Lip Conditions

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

- Orofacial surgery

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

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

Dental Anesthesia for Children

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

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

Diabetes Equipment, Education, and Supplies

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

Screenings for gestational diabetes are covered under "Preventive Care" later in this section.

Diagnostic Services

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

Diagnostic Laboratory and Pathology Services

- Laboratory and pathology tests, such as blood tests.
- Genetic tests, when allowed by us.

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.

Dialysis

Please see “Therapy Services” later in this section.

Durable Medical Equipment (DME), Medical Devices, and Supplies

Durable Medical Equipment and Medical Devices

Your Plan includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

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

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

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

Oxygen and equipment for its administration are also Covered Services.

Orthotics

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

Prosthetics

Your Plan also includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are required to adequately meet your needs.

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

1. Artificial limbs and accessories. For prosthetic arms and legs, we cover up to the benefits amounts provided by federal laws for Medicare or where needed to meet state insurance laws.
2. One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes.
3. Breast prosthesis (whether internal or external) and surgical bras after a mastectomy, as required by the Women's Health and Cancer Rights Act.
4. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
5. Restoration prosthesis (composite facial prosthesis).
6. Wigs needed after cancer treatment.
7. Cochlear implants.
8. For children under 18, subject to the terms of the Booklet, your Plan covers the following hearing aids and the services that go with them when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist:
    - Audiological testing to measure the level of hearing loss and to choose the proper make and model of a hearing aid. These evaluations will be provided under the prior "Diagnostic Services" of this section,
    - Hearing aids (monaural or binaural) including ear mold(s), bone-anchored hearing aids, the hearing aid instrument, batteries, cords, and other ancillary equipment. The Plan covers auditory training when it is offered using approved professional standards. Initial and replacement hearing aids will be supplied every 5 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 aids.

Medical and Surgical Supplies

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

Blood and Blood Products

Your Plan also includes coverage for the administration of blood products.

Emergency Care Services

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

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 Services

Benefits are available in a Hospital Emergency Room or freestanding Emergency Facility for services and supplies to treat the onset of symptoms, screen and stabilize an Emergency, which is defined below. **Services provided for conditions that do not meet the definition of Emergency will not be covered.**

Emergency (Emergency Medical Condition)

"Emergency," or "Emergency Medical Condition" means a medical or behavioral health condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition,

sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient's health or the health of another person in serious danger or, for a pregnant woman, placing the woman's health or the health of her unborn child in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions as may be determined to be Emergencies by us.

Emergency Care

"Emergency Care" means a medical or behavioral health exam within the capability of the Emergency Department of a Hospital or freestanding Emergency Facility, and includes ancillary services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient. Emergency Care may also include necessary services, including observation services, provided as part of the Emergency visit regardless of the department in which the services are provided.

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

Medically Necessary services will be covered whether you get care from an In-Network or Out-of-Network Provider.

Emergency Care you get from an Out-of-Network Provider will be covered as an In-Network service and will not require Precertification. Emergency Care provided in a Facility within Colorado will be covered as an In-Network service and, for Covered Emergency Services, you will not have to pay the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount. For other Covered Emergency Services from an Out-of-Network Provider, you will not need to pay more than what you would have if you had seen an In-Network Provider.

If you are admitted to the Hospital from the Emergency Room, be sure that you or your Doctor calls us as soon as you are stabilized. We will review your care to decide if a Hospital stay is needed and how many days you should stay. See "How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)" for more details.

Treatment you get after your condition has stabilized is not Emergency Care. Please refer to the "Consolidated Appropriations Act of 2021 Notice" at the beginning of this Booklet for more details on how this will impact your benefits.

Gender Affirming Health Services

Medically Necessary treatment for gender dysphoria includes non-surgical physical and behavioral health services, including but not limited to office visits, counseling, hormone therapy, laboratory services, preventive health services and Prescription Drugs. Medically Necessary treatment includes the following gender-affirming health services:

General procedures

- Laser or electrolysis hair removal

Breast/Chest Surgery (male to female)

- Augmentation mammoplasty
- Implants / lipofillings
- Breast / chest augmentation, reduction, construction

Genital Surgery (male to female)

- Penectomy
- Orchiectomy
- Vaginoplasty
- Dilator (medical equipment)
- Clitoroplasty
- Vulvoplasty
- Labiaplasty
- Prostatectomy
- Urethroplasty
- Vagina / perineum reconstruction

Non-Breast / Chest Surgical Interventions (male to female)

- Facial feminization surgery
- 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 recontouring
- Rhinoplasty (nose reshaping)
- Liposuction
- Lipofilling
- Voice surgery
- Thyroid cartilage reduction / reduction thyrochondroplasty
- Gluteal augmentation (implants / lipofilling)
- Hair reconstruction

Breast / Chest Surgery (female to male)

- Subcutaneous mastectomy (for creation of male chest)
- Simple / total mastectomy
- Partial mastectomy
- Modified radical mastectomy
- Radical mastectomy
- Breast reduction (reduction mammoplasty)
- Breast / chest augmentation, reduction, construction

Genital Surgery (female to male)

- Hysterectomy
- Ovariectomy / oophorectomy
- Salpingectomy
- Metoidioplasty
- Phalloplasty
- Vaginectomy
- Vulvectomy
- Scrotoplasty
- Urethroplasty
- Trachelectomy
- Penis / perineum reconstruction
- Implantation of erection and/or testicular prosthesis

Non-Genital, Non-Breast / Chest Surgical Interventions (female to male)

- Nipple reconstructions following mastectomy
- Voice therapy lessons
- Voice surgery
- Liposuction
- Lipofilling
- Pectoral implants

- Calf implants

Benefits must be approved for the type of surgery requested and procedures and/or services may be subject to Precertification as outlined in the "How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)" section. **Charges for services that are not authorized for the surgery requested may not be considered Covered Services. Some conditions and age restrictions may apply.**

We will not deny, exclude or otherwise limit coverage for Medically Necessary services, in accordance with generally accepted professional standards of care, based upon a person's sexual orientation or gender identity. Cost shares will be determined by place of service and the Covered Services received. For example, an In-Network outpatient surgical procedure will be covered the same as any other covered Medically Necessary In-Network outpatient surgical procedure.

Habilitative Services

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

Please see "Therapy Services" later in this section for further details.

Home Health Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Home Health Care Provider in your home. Home Health Care is covered only when such care is necessary as an alternative to Hospital stay. Prior Hospital stay is not required. Home Health Care must be prescribed by a Doctor, under a plan of care established by the Doctor in collaboration with a Home Health Care Agency. We must preauthorize all care and reserve the right to review treatment plans at periodic intervals.

Covered Services include but are not limited to:

- Intermittent skilled nursing services by an R.N. or L.P.N.
- Medical / social services
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the Home Health Care Provider. Other organizations may give services only when approved by us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider or other Provider as approved by us.
- Therapy Services of physical, occupational, speech and language, respiratory and inhalation (except for Chiropractic Care / Manipulative Therapy, which will not be covered when given in the home)
- Medical supplies
- Durable medical equipment, prosthetics, and orthopedic appliances
- Private duty nursing services in the home

When available in your area, benefits are also available for Intensive In-home Behavioral Health Services. These do not require confinement to the home. These services are described in the "Mental Health and Substance Use Disorder Services" section below.

Benefits may also be available for Inpatient Services in your home. These benefits are separate from the Home Health Care Services benefit, and are described in the “Inpatient Services” section below.

Home Infusion Therapy

Please see “Therapy Services” later in this section.

Hospice Care

You are eligible for hospice care if your Doctor and the Hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating Provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms but is not meant to cure a terminal illness. Hospice care includes routine home care, constant home care, inpatient Hospice, and inpatient respite. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term Inpatient Hospital care when needed in periods of crisis or as respite care.
- Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- Doctor services and diagnostic testing.
- Social services and counseling services from a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes and nutritional counseling.
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- Prosthetics and orthopedic appliances.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member’s death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated caregiver and individuals with significant personal ties, for one year after the Member’s death.
- Transportation.

Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to us upon request.

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan. Any care you get that has to do with an unrelated illness or medical condition will be subject to the provisions of this plan that deals with that illness.

Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services

Your Plan includes coverage for Medically Necessary human organ and tissue transplants as well as certain cellular and gene therapies. **To be eligible for coverage, we must approve the benefits in advance through Precertification and services must be performed by an Approved In-Network Provider to be covered at the In-Network level.**

Certain transplants (e.g., cornea) are covered like any other surgery, under the regular inpatient and outpatient benefits described elsewhere in this Booklet.

In this section you will see some key terms, which are defined below:

Covered Procedure

As decided by us, a Covered Procedure includes:

- Any Medically Necessary human solid organ, tissue, and stem cell / bone marrow transplants and infusions, and
- Any Medically Necessary cellular or other gene therapies, and
- Any Medically Necessary acquisition procedures, mobilization, collection, and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Approved In-Network Provider

A Provider who has entered into an agreement with us to provide Covered Procedures to you. The agreement may only cover certain Covered Procedures or all Covered Procedures. Approved In-Network Providers may include the following:

- **Blue Distinction Center (BDC) Facility:** Blue Distinction facilities have met or exceeded national quality standards for care delivery of Covered Procedures.
- **Centers of Medical Excellence (CME) Facility:** Centers of Medical Excellence facilities have met or exceeded quality standards for care delivery of Covered Procedures.

All Other Providers

Any Provider that is NOT an Approved In-Network Provider. This includes In-Network Providers who participate in the Plan's networks, but who are not an Approved In-Network Provider for a Covered Procedure, as well Out-of-Network Providers.

Prior Approval and Precertification

To maximize your benefits, you should call our Transplant Department as soon as you think you may need a Covered Procedure to talk about your benefit options. You must do this before you receive services. We will help you maximize your benefits by giving you coverage information, including details on what is covered as well as information on any clinical coverage guidelines, medical policies, Approved In-Network Provider rules, or Exclusions that apply. Call the Member Services phone number on the back of your Identification Card and ask for the transplant coordinator.

You or your Provider must call our Transplant Department for Precertification prior to the Covered Procedure whether this is performed in an Inpatient or Outpatient setting. Your Doctor must certify, and we must agree, that the Covered Procedure is Medically Necessary. Your Doctor should send a written request for Precertification to us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final decision as to what Covered Procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or collection and storage is NOT an approval for the later Covered Procedure. A separate Medical Necessity decision will be needed for the Covered Procedure.

Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging

for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to us when claims are filed. Call us for complete information or refer to the IRS Publication 502.

For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.

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

- Childcare,
- Mileage within the city where the Covered Procedure is performed,
- 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 Covered Procedure,
- Phone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel costs for donor companion/caregiver,
- Return visits for the donor for a treatment of an illness found during the evaluation,
- Meals.

Infertility Services

Please see “Maternity and Reproductive Health Services” later in this section.

Inpatient Services

Inpatient Hospital Care

Covered Services include acute care in a Hospital setting*.

Benefits for room, board, and nursing services include:

- A room with two or more beds.
- A private room. The most 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.
- Newborn care for during and after the mother’s maternity Hospital stay for treatment of injury and sickness and medically diagnosed Congenital Defects and Birth Abnormalities.
- Meals, special diets.
- Private duty nursing services when Medically Necessary.
- General nursing services.

Benefits for ancillary services include:

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

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when your condition requires it.
- 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.

*When available in your area, certain Providers have programs available that may allow you to receive Inpatient Services in your home instead of staying in a Hospital. To be eligible, your condition and the Covered Services to be delivered must be appropriate for the home setting. Your home must also meet certain accessibility requirements. These programs are voluntary and are separate from the benefits under “Home Health Care Services.” Your Provider will contact you if you are eligible, and provide you with details on how to enroll. If you choose to participate, the cost shares listed in your “Schedule of Benefits (Who Pays What)” under “Inpatient Services” will apply.

Maternity and Reproductive Health Services

Maternity Services

Covered Services include services needed during a normal or complicated pregnancy, Complications of Pregnancy, and for services needed for a miscarriage. Covered maternity services include:

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

If you are pregnant on your Effective Date and in the first trimester of the pregnancy, you must change to an In-Network Provider to have Covered Services covered at the In-Network level. If you are pregnant on your Effective Date and in your second or third trimester of pregnancy (13 weeks or later) as of the Effective Date, benefits for obstetrical care will be available at the In-Network level even if an Out-of-Network Provider is used if you fill out a Continuation of Care Request Form and send it to us. Covered

Services will include the obstetrical care given by that Provider through the end of the pregnancy and the immediate post-partum period.

Important Note About Maternity Admissions: Under federal law, we may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). If the baby is born between 8:00 p.m. and 8:00 a.m., coverage will continue until 8:00 a.m. on the morning after the 48- or 96-hours timeframe. However, federal law as a rule does not stop the mother's or newborn's attending Provider, after consulting with 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 authorization from us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Contraceptive Benefits

We cover all eighteen (18) forms of emergency and preventive contraception approved by the FDA at no-cost to the consumer and included in the Health Resources and Services Administration (HRSA) Women's Preventive Services Guidelines. These include, tubal ligation, various intrauterine devices IUDs), implants, shots, oral contraceptives (sometimes known as "the pill"), patches, vaginal rings, diaphragms, sponges, cervical caps, female condoms, spermicide, and emergency contraceptives (sometimes known as "Plan B"). The no-cost coverage also includes contraceptive counseling, initiation of contraceptive use, and follow-up care (e.g., office visits, management, evaluation, associated laboratory testing, as well as changes to and removal or discontinuation of the contraceptive method). Over-the-counter and emergency contraception is also covered at no-cost with or without a Prescription.

We cover twelve (12) months of a prescription contraceptive at one time.

While we may utilize certain medical management techniques to prioritize coverage of one medication or item in the same category, it does not use the following techniques, as they create unreasonable delay: denial of coverage for all or particular Brand Name contraceptives; fail-first or step therapy requirements; and age limitations on coverage.

If you require a different type of contraception, we will cover, without cost to the Member, any necessary contraceptive service or item, and we will defer to your Physician's determination. We have an exceptions process to request a different type of contraception that is easily accessible, transparent, sufficiently expedient, and not unduly burdensome on you or your Physician. Your Physician must complete a contraceptive exception form and return it us. You or your Physician can find the form online at https://fm.formularynavigator.com/FormularyNavigator/DocumentManager/Download?clientDocumentId=LAKA38IJDUGiKBiuoAUg-g. Call the number listed on the back of your ID Card for more information about the exceptions process.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered. Sterilizations for women are covered under the "Preventive Care" benefit.

Abortion Services

Benefits include services for therapeutic or elective abortion regardless if Medically Necessary, unless applicable law or regulation prohibits the Group from providing such coverage (in which case, Covered Services are provided only to the extent necessary to prevent the death of the mother or unborn baby).

Infertility Services

Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis.

As part of other Covered Services under this Plan, benefits may also include services to treat the underlying medical conditions that may be associated with involuntary infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency), when received from an In-Network Provider. Covered Services also includes artificial insemination that satisfies Anthem's 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.

Medical Foods

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

- Phenylketonuria, if you are 21 or younger (35 or younger for women of child-bearing age),
- Maternal phenylketonuria,
- Maple syrup urine disease,
- Tyrosinemia,
- Homocystinuria,
- Histidinemia,
- Urea cycle disorders,
- Hyperlysinemia,
- Glutaric acidemias,
- Methylmalonic acidemia,
- Propionic acidemia,
- Immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins,
- Severe food protein induced enterocolitis syndrome,
- Eosinophlic disorders as evidenced by the results of a biopsy, and
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.

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

Mental Health and Substance Use Disorder Services

Covered Services include the following:

- **Inpatient Services** in a Hospital or any Facility that we must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
  - Observation and assessment by a physician weekly or more often,
  - Rehabilitation and therapy.
- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, Intensive Outpatient Programs and (when available in your area) Intensive In-Home Behavioral Health Services.
- **Online Visits**. 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 lab or other test results, requesting office visits, getting answers to billing, insurance coverage or

payment questions, asking for Referrals to doctors outside the online care panel, benefit Precertification, or Doctor to Doctor discussions. Online visits are not the same as Telehealth Services and can, at times, include audio-only interactions but generally do not include store-and-forward transfers.

- **Medication-Assisted Treatment**. A combination of behavioral therapies and medications approved by the FDA to treat substance use disorders is a covered benefit. This coverage includes services provided by opioid treatment programs for methadone administration and maintenance for the treatment of opioid use disorder.
- Substance use disorder treatment will be available regardless of whether the treatment is voluntary or court-ordered as a result of contact with the criminal justice system.
- For treatment of serious mental illness (SMI), when step therapy is mandated, a covered Member is required to try only one (1) alternative Prescription Drug before receiving coverage for the medication prescribed by their Doctor. SMI, as defined by the American Psychiatric Association in the latest Diagnostic and Statistical Manual of Mental Disorders, including the following:
  - Bipolar disorders (hypomanic, manic depressive, and mixed);
  - Depression in childhood and adolescence;
  - Major depressive disorders (single episode or recurrent);
  - Obsessive-compulsive disorders;
  - Paranoid and other psychotic disorders;
  - Schizoaffective disorders (bipolar or depressive); and
  - Schizophrenia.

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

The use of body mass index (BMI) or ideal body weight (IBW) or any other standard requiring an achieved weight will not be utilized to determine Medical Necessity or level of care appropriateness of the treatment of eating disorders, including but not limited to bulimia nervosa, atypical anorexia nervosa, binge-eating disorder, avoidant restrictive food intake disorder, and other specified feeding and eating disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

BMI or IBW will not be a determining factor when assessing Medical Necessity or level of care appropriateness for treatment of anorexia nervosa, restricting subtype, or binge-eating / purging subtype as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Examples of Providers from whom you can receive Covered Services include:

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

Occupational Therapy

Please see “Therapy Services” later in this section.

Office and Home Visits

Covered Services include:

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

Consultations between your Primary Care Physician and a Specialist, when approved by Anthem.

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

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

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

Urgent Care as described in "Urgent Care Services" later in this section.

Virtual Visits as described under the "Virtual Visits (Telemedicine / Telehealth Visits)" section.

Hearing Exams and tests to determine the need for hearing correction. For additional information on hearing aid services, please see "Durable Medical Equipment (DME), Medical Devices, and Supplies" earlier in this section.

Prescription Drugs Administered in the Office

Orthotics

Please see "Durable Medical Equipment (DME), Medical Devices, and Supplies" earlier in this section.

Outpatient Facility Services

Your Plan includes Covered Services in an:

- Outpatient Hospital,
- Freestanding Ambulatory Surgery Center,
- Mental Health / Substance Use Disorder Facility, or
- Other Facilities approved by us.

Benefits include Facility and related (ancillary) charges, when proper, 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.

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable state law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use an In-Network Provider.

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

Covered Services fall under the following broad groups:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
  - Breast cancer,
  - Cervical cancer,
  - Colorectal cancer,

    Note: 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.
  - High blood pressure,
  - Type 2 Diabetes Mellitus,
  - Cholesterol,
  - Child and adult obesity.

  Tobacco use screening and tobacco cessation counseling and intervention is also covered.
- Immunizations for children, adolescents, and adults, including cervical cancer vaccinations for females, where recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention,
- At least one mental health wellness exam every Benefit Period, to the extent required by applicable law.
- Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration,
- Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:
  - Women's contraceptives, sterilization treatments, and counseling. This includes Generic oral contraceptives as well as other contraceptive medications such as injectable contraceptives and patches, for the durations or supply minimums required by applicable law. Contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants are also covered. At least one product in all 18 approved methods of contraception is covered under this policy without cost sharing as required by federal and state law. Some categories and classes of contraceptives do not have Generics available and, in each of these categories, at least one Brand Drug is available at $0 cost sharing when you receive it from an In-Network Provider. If your Provider determines that a Brand Drug with an available Generic therapeutic equivalent is Medically Necessary because a Generic equivalent drug is not appropriate for you, you may obtain coverage of the Brand Drug with $0 cost-sharing if your Provider submits an exception request. Your Doctor must complete a contraceptive exception form and return it to us. You or your Doctor can find the form online at https://file.anthem.com/Anthem_ABS_BrandContraceptiveCopayWaiverForm.pdf or by calling the number listed on the back of your ID Card. If Medical Necessity has been determined by your Provider, an exception will be granted and coverage of the Drug will be provided at $0

cost sharing. Otherwise, Brand Drugs will be covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy.”

- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
- Gestational diabetes screening.

- Preventive care services for smoking cessation and tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
  - Counseling
  - Prescription Drugs obtained at a Retail or Home Delivery (Mail Order) Pharmacy
  - Nicotine replacement therapy products obtained at a Retail or Home Delivery (Mail Order) Pharmacy when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges, and patches.
- 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
  - Coverage is provided for HIV pre-exposure prophylaxis (PrEP), including baseline and monitoring services consistent with USPSTF recommendations, for federal Food and Drug Administration FDA-approved medications without copayment, coinsurance, or other cost-sharing.

    FDA approved HIV PrEP medications listed on our formulary are not subject to step therapy or prior authorization requirements. Non-formulary FDA approved HIV PrEP medications are not subject to step therapy or prior authorization when prescribed or dispensed by a pharmacist. Requests from a non-pharmacist Provider for FDA-approved non-formulary HIV PrEP medications shall be processed on an urgent basis within 24 hours of receipt.

  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, and http://www.cdc.gov/vaccines/acip/index.html.

Preventive Care for Chronic Conditions (per IRS guidelines)

Members with certain chronic health conditions may be able to receive preventive care for those conditions prior to meeting their Deductible, when services are provided by an In-Network Provider. These benefits are available if the care qualifies under guidelines provided by the Treasury Department, Internal Revenue Service (IRS), and Department of Health and Human Services (HHS) (referred to as “the agencies”). Details on those guidelines can be found on the IRS’s website at the following link:

https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain-care-for-chronic-conditions

The agencies will periodically review the list of preventive care services and items to determine whether additional services or items should be added or if any should be removed from the list. You will be notified if updates are incorporated into your Plan.

Please refer to the “Schedule of Benefits (Who Pays What)” for further details on how benefits will be paid.

Prosthetics

Please see “Durable Medical Equipment (DME), Medical Devices, and Supplies” earlier in this section.

Pulmonary Therapy

Please see “Therapy Services” later in this section.

Radiation Therapy

Please see “Therapy Services” later in this section.

Rehabilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary, and you stop progressing toward those goals.

Please see “Therapy Services” in this section for further details.

Respiratory Therapy

Please see “Therapy Services” later in this section.

Skilled Nursing Facility

When you require Inpatient skilled nursing and related services for convalescent, rehabilitative or habilitative care, Covered Services are available if the Facility is licensed or certified under state law as a Skilled Nursing Facility, or is otherwise licensed to provide the services. Custodial Care is not a Covered Service.

Smoking Cessation

Please see the “Preventive Care” section in this Booklet.

Speech Therapy

Please see “Therapy Services” later in this section.

Surgery

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

- Accepted operative and cutting procedures,
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine,
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy,
- Treatment of fractures and dislocations,
- Anesthesia and surgical support when Medically Necessary,
- Medically Necessary pre-operative and post-operative care.

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 Anthem’s medical policy. You or your Physician must obtain Precertification for all bariatric surgical procedures.

Oral Surgery

Important Note: Although this Plan covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered, except as listed in this Booklet.

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 as indicated in the "Dental Services (All Members / All Ages)" section.
- 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.

Your Plan also covers certain oral surgeries for children. Please refer to "Pediatric Dental Services for Members through Age 18" for details.

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.

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

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.

When due to breast cancer, reconstructive and surgical coverage will be provided in a manner determined in consultation with the attending Physician and the Member. Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Plan.

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, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

Physical Medicine Therapy Services

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

For age 6 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.
- **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.
- **Post-cochlear implant aural therapy** – Services to help a person understand the new sounds they hear after getting a cochlear implant.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts, and crafts.
- **Chiropractic Care / Osteopathic / Manipulative therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but Chiropractic Care / Manipulative Therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons, and ligaments. Chiropractic benefits are Covered Services only when received from an In-Network Provider and are limited to office visits for evaluation, manual manipulation of the spine, laboratory services, X-ray of the spine and certain physical modalities and procedures for musculoskeletal disorders.
- **Massage therapy** – Injury or illness for which massage has a therapeutic result. Coverage is provided for up to a 60-minute session per visit. Some Covered Services include acupressure and deep tissue massage, or other approved services.
- **Acupuncture** – Treatment by means of inserting needles into the body to reduce pain or induce anesthesia. It may also be used for diagnoses as determined appropriate by the Provider. It is recommended that acupuncture be part of a coordinated plan of care approved by the Member's Doctor. These benefits cover acupuncture and acupressure treatment.

Early Intervention Services

From the Member's birth until the Member's third (3rd) birthday, this Plan covers Early Intervention Services (as defined in this Booklet and by Colorado law in accordance with part C), 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 or services provided to a child who is not participating in part C. The coverage for Early Intervention Services is in addition to any other coverage provided under this Booklet 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. Covered Services also include home dialysis and training for you and the person who will help you with home self-dialysis.
- **Infusion Therapy** – Nursing, durable medical equipment and Drug services that are delivered and administered to you through an I.V. in your home. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes outpatient short-term respiratory care to restore your health after an illness or injury.
- **Cognitive Rehabilitation Therapy** – Medically Necessary cognitive rehabilitation, including therapy following a post-traumatic brain injury or cerebral vascular accident.
- **Radiation Therapy** – Treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon, or high energy particle sources), materials and supplies needed, and treatment planning.
- **Respiratory Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Transplant Services

Please see "Human Organ and Tissue Transplant" earlier in this section.

Urgent Care Services

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

Benefits for urgent care include:

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

Virtual Visits (Telemedicine / Telehealth Visits)

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 virtual care-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 lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for Referrals to doctors outside the online care panel, benefit

Precertification, or doctor to doctor discussions. 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 Use Disorder Online Visits, see the “Mental Health and Substance Use Disorder 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 Service at the number on the back of your Identification Card.

Vision Services for Members Through Age 18

These vision care services are covered for Members until the end of the month in which they turn 19. To get In-Network benefits, you must 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. See the “Schedule of Benefits (Who Pays What)” to see your Deductible, Coinsurance, Copayment, and other benefit limitations.

Routine Eye Exam

This Plan 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 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 cost and which ones will cost you more.

Contact Lenses

Each Benefit Period, you can 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 Benefit Period. 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 – Elective contact lenses are ones you choose for comfort or appearance.
- Non-Elective Contact Lenses – Non-elective contact lenses are ones prescribed for certain eye conditions:

- Keratoconus when your vision 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.

Vision Services for Members Age 19 and Older

These vision care services are covered for Members age 19 or older. 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. See the "Schedule of Benefits (Who Pays What)" to see your Deductible, Coinsurance, Copayment, and other benefit limitations.

Routine Eye Exam

This Plan 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, or trifocal (FT 25-28). Additional covered lens options may be available to you. See the "Schedule of Benefits (Who Pays What)" for more information.

Frames

You have an allowance to use toward the purchase of any frame. If the frame you choose is more than your allowance, you will have to pay the difference.

Contact Lenses

You have an allowance to use toward contact lenses. If you choose contact lenses that are more than your allowance, you will have to pay the difference. Each Benefit Period, you can use your 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 Benefit Period.

- Elective Contact Lenses – Elective contact lenses are ones you choose for comfort or appearance.
- Non-Elective Contact Lenses – Non-elective contact lenses are ones prescribed for certain eye conditions:
  - Keratoconus when your vision 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.

Vision Services (All Members / All Ages)

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.

Benefits do not include glasses or contact lenses except as listed in the "Prosthetics" benefit.

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 when they 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 benefits (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 or Home Delivery (Mail Order) 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 an Anthem Prescription Drug List (a formulary developed by Anthem) which is a list of FDA approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The following are not subject to step therapy, as required under applicable state law:

- FDA-approved Prescription Drugs listed on our formulary for HIV prevention and treatment.
- FDA-approved Prescription Drugs listed on our formulary for the treatment of substance use disorders, defined as alcohol use disorder, opioid use disorder, opioid reversal agents, and nicotine dependence.
- stage four metastatic cancer Prescription Drugs.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and Controlled Substances must be prescribed by a licensed Provider with an active DEA license.

Compound ingredients within a compound drug are a Covered Service when a commercially available dosage form of a Medically Necessary medication is not available, ingredients of the compound drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Precertification

Precertification may be required for certain Prescription Drugs to help 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.

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 (Applicable to managed care plans)” under “Getting 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 Booklet.

The following are not subject to precertification:

- HIV treatment and prevention medications listed on the formulary.
- FDA-approved Prescription Drug listed on our formulary for the treatment of substance use disorders, defined as alcohol use disorder, opioid use disorder, opioid reversal agents, and nicotine dependence. At least one FDA-approved medication for the treatment of each defined substance use disorder is available on the lowest tier of the formulary.

Designated Pharmacy Provider

Anthem 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. Anthem 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 Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Therapeutic Equivalents

Therapeutic equivalents is a 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 equivalent is right for you. For questions or issues about therapeutic Drug equivalents, call Member Services at the phone number on the back of your Identification Card.

Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy

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

Please 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 prior authorization to determine if your Drugs should be covered. Your In-Network Pharmacist will be told if prior authorization is required and if any additional details are needed for us to decide benefits.

Prior Authorization

Prescribing Providers must obtain prior authorization in order for you to get benefits for certain Drugs. At times, your Provider will initiate a prior authorization on your behalf before your Pharmacy fills your Prescription. At other times, the Pharmacy may make you or your Provider aware that a prior authorization 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).

The following are not subject to step therapy, as required under applicable state law:

- FDA-approved Prescription Drugs listed on our formulary for HIV prevention and treatment.
- FDA-approved Prescription Drugs listed on our formulary for the treatment of substance use disorders, defined as alcohol use disorder, opioid use disorder, opioid reversal agents, and nicotine dependence.
- stage four metastatic cancer Prescription Drugs.

Where required by applicable law, we will cover the initial five-day supply (within a twelve 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 prior authorization by calling 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.

Anthem may, from time to time, waive, enhance, change or end certain prior authorization and/or offer alternate benefits, if in our sole discretion, such change furthers the provision of cost effective, value based and/or quality services.

Expedited prior authorization – We will review Expedited requests for prior authorization 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 prior authorization request will be deemed denied.

Non-Expedited prior authorization – We will review non-Expedited requests for prior authorization 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.

If prior authorization is denied you have the right to file a Grievance as outlined in the “Appeals and Complaints” section of this Booklet.

The following are not subject to prior authorization:

- HIV treatment and prevention medications listed on the formulary.
- FDA-approved Prescription Drug listed on our formulary for the treatment of substance use disorders, defined as alcohol use disorder, opioid use disorder, opioid reversal agents, and nicotine dependence. At least one FDA-approved medication for the treatment of each defined substance use disorder is available on the lowest tier of the formulary.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy. Controlled Substances must be prescribed by a licensed Provider with an active 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” benefit. Please see that section for more details,

  Note: A Prescription contraceptive provided by an In-Network Pharmacy can be dispensed to a Member for a 12-month supply.
- Special food products or supplements, including metabolic formulas, when prescribed by a Doctor if we agree they are Medically Necessary,
- Flu Shots (including administration). These will be covered under the “Preventive Care” benefit,
- Immunizations (including administration) required by the “Preventive Care” benefit,
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the “Preventive Care” benefit,
- FDA approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 or older. These products will be covered under the “Preventive Care” benefit,
- Compound ingredients within compound drugs when a commercially available dosage form of a Medically Necessary medication is not available, ingredients of the compound drug are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

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

- the off-label use of the FDA approved drug is supported for the treatment of cancer by the authoritative reference compendia identified by the Department of Health and Human Services; and

- the condition being treated is covered under this Booklet.

Where You Can 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.

Important 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 Booklet.

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 In-Network 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 Booklet.

Maintenance Pharmacy

You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. 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 or need to determine if your Pharmacy is a Maintenance Pharmacy, please call Member Services at the number on the back of your Identification Card or check our website at www.anthem.com for more details.

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 prior authorization 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 Member Services at the phone number on the back of your Identification Card or check our website at www.anthem.com.

Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy that lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can have your Doctor send Prescriptions electronically, via fax or phone call, or you can submit written Prescriptions from your Doctor to the Home Delivery Pharmacy.

Out-of-Network Pharmacy

You may also use a Pharmacy that is not in our network. You will be charged the full retail price of the Drug and you will have to send your claim for the Drug to us. (Out-of-Network Pharmacies won't file the claim for you.) You can get a claims form from us or the PBM. You must fill in the top section of the form and ask the Out-of-Network Pharmacy to fill in the bottom section. If the bottom section of this form cannot be filled out by the pharmacist, you must attach a detailed receipt to the claim form. The receipt must show:

- Name and address of the Out-of-Network Pharmacy,
- Patient's name,
- Prescription number,
- Date the prescription was filled,
- Name of the Drug,
- Cost of the Drug,
- Quantity (amount) of each covered Drug or refill dispensed.

You must pay the amount shown in the "Schedule of Benefits (Who Pays What)". This is based on the Maximum Allowed Amount as determined by our normal or average contracted rate with network pharmacies on or near the date of service.

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:

- Tier 1a 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.
- Tier 1b Drugs have a higher Coinsurance or Copayment than those in Tier 1a. 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.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1a and b. This tier may contain preferred Drugs that may be Generic, single source, Brand Drugs, Biosimilars, Interchangeable Biologic Products, 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, Brand Drugs, Biosimilars, Interchangeable Biologic Products, 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 Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.

We assign drugs to tiers based on clinical findings from the Pharmacy and Therapeutics (P&T) Process. We retain the right, at our discretion, to decide coverage for doses and administration (i.e., oral, injection, topical, or inhaled). We may cover one form of administration instead of another or put other forms of administration in a different tier.

Prescription Drug List

We also have an Anthem 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 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.

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

You may request a copy of the covered Prescription Drug list by calling the Member Services telephone number on the back of your Identification Card or visiting our website at www.anthem.com. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Exception Request for a Drug not on the Prescription Drug List

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

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

Coverage of a Drug approved as a result of your request or your Doctor’s request for an exception will only be provided if you are a Member enrolled under the Plan. For additional information about the exception processes for Drugs not included on your Plan’s Prescription Drug List, please call the Member Services telephone number on the back of your Identification Card.

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 Drops 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 Member Services at the number on the back of your Identification Card.

Note: A Prescription contraceptive provided by an In-Network Pharmacy can be dispensed to a Member for a 12-month supply.

Therapeutic Equivalents

Therapeutic equivalents is a 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 equivalent is right for you. For questions or issues about therapeutic Drug equivalents, call 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 number on your member ID card or log on to the website at www.anthem.com.

Special Programs

Except when 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.

Rebate Impact on Prescriptions Drugs You get at Retail or Home Delivery Pharmacies

Anthem and/or its PBM may also, from time to time, enter into agreements that result in Anthem 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 Anthem 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 of 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.

Section 8. Limitations/Exclusions (What is Not Covered)

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

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

1) **Administrative Charges**
   a) Charges to complete claim forms,
   b) Charges to get medical records or reports,
   c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.
2) **Aids for Non-verbal Communication** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Anthem.
3) **Alternative / Complementary Medicine** Services or supplies for alternative or complementary medicine, regardless of the Provider rendering such services or supplies. This includes, but is not limited to:
   a. Holistic medicine,
   b. Acupressure, or massage to help alleviate pain, treat illness, or promote health by putting pressure to one or more areas of the body, except as specifically listed as a Covered Service in this Plan,
   c. Homeopathic medicine,
   d. Hypnosis,
   e. Aroma therapy,
   f. Reiki therapy,
   g. Herbal, vitamin or dietary products or therapies,
   h. Naturopathy,
   i. Thermography,
   j. Orthomolecular therapy,
   k. Contact reflex analysis,
   l. Bioenergetics synchronization technique (BEST),
   m. Iridology-study of the iris,
   n. Auditory integration therapy (AIT),
   o. Colonic irrigation,
   p. Magnetic innervation therapy,
   q. Electromagnetic therapy,
   r. Neurofeedback / Biofeedback.
4) **Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis) for all indications except as described under Autism Services in the “Benefits/Coverage (What is Covered)” section unless otherwise required by law.

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

6) **Before Effective Date or After Termination Date** Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.

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

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

9) **Charges Over the Maximum Allowed Amount** Charges over the Maximum Allowed Amount for Covered Services, except for Surprise Billing Claims as outlined in the "Consolidated Appropriations Act of 2021 Notice" in the beginning of this Booklet.

10) **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.

11) **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.

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

13) **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles, and/or pharmaceutical adjuvants.

14) **Cosmetic Services** Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change**,** or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts) unless required by law. This exclusion does not apply to Medically Necessary gender affirming health services.

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

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

17) **Cryopreservation** Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.

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

19) **Delivery Charges** Charges for delivery of Prescription Drugs.

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

21) **Dental Services**

- Dental care for Members age 19 or older, unless listed as covered in the medical benefits of this Booklet.
- Dental services or health care services not specifically covered in this Booklet (including any hospital charges, prescription drug charges and dental services or supplies that do not have an

American Dental Association Procedure Code, unless covered by the medical benefits of this Plan).

- Services of anesthesiologists, unless required by law.
- Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. Note: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
- Anesthesia services (such as intravenous conscious sedation, IV 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. Includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Dental services or supplies 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.
- Occlusal or athletic mouth guards.
- Prosthodontic services (such as dentures or bridges) and periodontal services (such as scaling and root planing).
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Separate services billed when they are an inherent component of another covered service.
- Services to treat Temporomandibular Joint Disorder (TMJ) except as covered under your medical coverage.
- Oral hygiene instruction, including guidance regarding home care. Some examples of oral hygiene instructions include instructions or guidance on tooth brushing technique, flossing, and/or use of special oral hygiene aids.
- Case presentations of detailed treatment plans, office visits during and after regularly scheduled hours, when no other services are performed.
- Implant services, except as listed in this Booklet.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling materials, nor the procedures used to prepare and place material(s) in the canals (tooth roots).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment, and bleaching of discolored teeth.
- Incomplete root canals.
- Secondary diagnostic tests in addition to the primary therapy.

22) **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.

23) **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.

24) **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.

25) **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.

26) **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 or other Drugs provided in the Preventive Care paragraph of the "Benefits/Coverage (What is Covered)" section.

27) **Educational Services** Services, supplies or room and board for teaching, vocational, or self-training purposes, except as listed in this Booklet. This includes but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

28) **Emergency Room Services for non-Emergency Care** Services provided in an emergency room for conditions that do not meet the definition of Emergency. This includes, but is not limited to, suture removal, routine pregnancy test, sore throat, earache/infection, rashes, sprains/strains, constipation, diarrhea, upper respiratory illness, abrasions, sleep disorder, conjunctivitis/pink eye, back pain that is not sudden and severe in onset, or dental caries/cavity in an emergency room. For non-emergency care please use the closest network Urgent Care Center or your Primary Care Physician.

29) **Experimental or Investigational Services** Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.

    The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.

30) **Eyeglasses and Contact Lenses** Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.

31) **Eye Exercises** Orthoptics and vision therapy.

32) **Eye Surgery** Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy.

33) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

34) **Foot Care** Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:

    a) Cleaning and soaking the feet.

    b) Applying skin creams to care for skin tone.

    c) Other services that are given when there is not an illness, injury or symptom involving the foot.

35) **Foot Orthotics** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.

36) **Foot Surgery** Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.

37) **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

38) **Free Care** Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.

    If your Group is not required to have Workers Compensation coverage, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part.

39) **Growth Hormone Treatment** Any treatment, device, drug, service, or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

40) **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.

41) **Hearing Aids** Hearing aids or exams to prescribe or fit hearing aids, including bone-anchored hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.

42) **Home Health Care**

    a) Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider.

    b) Food, housing, homemaker services and home delivered meals.

43) **Hospital Services Billed Separately** Services rendered by Hospital resident Doctors or interns that are billed separately. This includes separately billed charges for services rendered by employees of Hospitals, labs or other institutions, and charges included in other duplicate billings.

44) **Hyperhidrosis Treatment** Medical and surgical treatment of excessive sweating (hyperhidrosis).

45) **Infertility Treatment** Infertility procedures not specified in this Booklet.

46) **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

47) **Maintenance Therapy** Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services" as described in the "Benefits/Coverage (What is Covered)" section.

48) **Medical Equipment, Devices, and Supplies**

    a) Replacement or repair of purchased or rental equipment because of misuse, or loss/theft.

    b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

    c) Non-Medically Necessary enhancements to standard equipment and devices.

    d) Supplies, equipment, and appliances including hearing aids and wigs, 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, including items you purchase with features that exceed what is Medically Necessary, will be limited to the Maximum Allowed Amount for the standard item, and the additional costs will be your responsibility.

    e) Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

49) **Medicare** For which benefits are payable under Medicare Parts A and/or B, except as required by law, as described in the section titled "Medicare" in "General Policy Provisions".

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

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

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

53) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

54) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

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

56) **Oral Surgery** Extraction of teeth, surgery for impacted teeth and other oral surgeries to treat the teeth or bones and gums directly supporting the teeth, except as listed in this Booklet.

57) **Out-of-Network Services** Services received from an Out-of-Network Provider, as specified in the "Schedule of Benefits (Who Pays What)" Section of this Booklet.

58) **Personal Care, Convenience and Mobile/Wearable Devices**

   a) Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs.

   b) First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads).

   c) Home workout or therapy equipment, including treadmills and home gyms.

   d) Pools, whirlpools, spas, or hydrotherapy equipment.

   e) Hypoallergenic pillows, mattresses, or waterbeds.

   f) Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).

   g) Consumer wearable / personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

59) **Private Duty Nursing** Private Duty Nursing Services given in a Skilled Nursing Facility. Private duty nursing services are a Covered Service only when given as part of the "Home Health Care Services" and "Inpatient Services" benefits.

60) **Prosthetics** Prosthetics for sports or cosmetic purposes.

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

   a) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

   b) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

   c) Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward-bound programs, even if psychotherapy is included.

   d) Services or care billed by a program or facility that principally or primarily provides services for individuals with a medical or Mental Health and Substance Use Disorder diagnosis or condition in an outdoor environment, including wilderness, adventure, outdoor programs or camps.

62) **Routine Physicals and Immunizations** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under the “Preventive Care” benefit.

63) **Services Not Appropriate for Virtual Telemedicine / Telehealth Visits** Services that we determine require in-person contact and/or equipment that cannot be provided remotely.

64) **Sexual Dysfunction** Services or supplies for male or female sexual problems.

65) **Stand-By Charges** Stand-by charges of a Doctor or other Provider.

66) **Sterilization** Services to reverse an elective sterilization.

67) **Surrogate Mother Services** Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

68) **Temporomandibular Joint Treatment** Fixed or removable appliances that move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

69) **Travel Costs** Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.

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

71) **Vision Services**

- Vision services not specifically listed as covered in this Booklet.
- For services or supplies combined with any other offer, coupon, or in-store advertisement, or for certain brands of frames where the manufacture does not allow discounts.
- Safety glasses and accompanying frames.
- For two pairs of glasses in lieu of bifocals.
- Plano lenses (lenses that have no refractive power).
- Lost or broken lenses or frames unless the Member has reached their normal interval for service when seeking replacements.
- Blended lenses.
- Oversize lenses.
- Sunglasses.
- For Members through age 18, no benefits are available for frames and contact lenses purchased outside of our formulary.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.

72) **Waived Cost-Shares Out-of-Network** For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

73) **Weight Loss Programs** Programs, whether or not under medical supervision, unless listed as covered in this Booklet.

This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

74) **Weight Loss Surgery** Services and supplies related to bariatric surgery, or surgical treatment of obesity, unless listed as covered in the Booklet.

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

1) **Administration Charges** Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
2) **Charges Not Supported by Medical Records** Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
3) **Clinical Trial Non-Covered Services** Any Investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-Investigational treatments.
4) **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.
5) **Compound Ingredients** Compound ingredients that are not FDA approved or do not require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles, and/or pharmaceutical adjuvants.
6) **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.
7) **Delivery Charges** Charges for delivery of Prescription Drugs.
8) **Drugs Given at the Provider's Office / Facility** Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit – they are Covered Services.
9) **Drugs Not on the Anthem Prescription Drug List (a formulary)** You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to "Prescription Drug List" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.
10) **Drugs Over Quantity or Age Limits** Drugs which are over any quantity or age limits set by the Plan or us.
11) **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.
12) **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 Anthem.
13) **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 or other Drugs provided in the Preventive Care paragraph of the "Benefits/Coverage (What is Covered)" section.
14) **Family Members** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
15) **Fraud, Waste, Abuse, and Other Inappropriate Billing** Services from an Out-of-Network Provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing

activities. This includes an Out-of-Network Provider's failure to submit medical records required to determine the appropriateness of a claim.

16) **Gene Therapy** Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material. While not covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit, benefits may be available under the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" benefit. Please see that section for details.

17) **Growth Hormone Treatment** Any treatment, device, drug, service, or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

18) **Hyperhidrosis Treatment** Prescription Drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).

19) **Infertility Drugs** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT), except as listed in this Booklet.

20) **Items Covered as Durable Medical Equipment (DME)** Therapeutic DME, devices and supplies except peak flow meters, spacers, and glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment (DME), Medical Devices, and Supplies" benefit. Please see that section for details.

21) **Items Covered Under the "Allergy Services" Benefit** Allergy desensitization products or allergy serum. While not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.

22) **Lost or Stolen Drugs** Refills of lost or stolen Drugs.

23) **Mail Order Providers other than the PBM's Home Delivery Mail Order Provider** Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider unless we must cover them by law.

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

25) **Non-Medically Necessary Services** Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.

26) **Nutritional or Dietary Supplements** Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.

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

28) **Onychomycosis Drugs** Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immuno-compromised or diabetic.

29) **Over-the-Counter Items** Drugs, devices and products, or Prescription Drugs with over-the-counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over-the-counter Drug, device, or product may not be covered, even if written as a Prescription. This includes Prescription Drugs when any version or strength becomes available over the counter.

    This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription.

30) **Sexual Dysfunction Drugs** Drugs to treat sexual or erectile problems.

31) **Syringes** Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

32) **Weight Loss Drugs** Any Drug mainly used for weight loss.

Section 9. Member Payment Responsibility

Your Cost-Shares

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

Maximum Allowed Amount

General

This section 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 this Booklet's Maximum Allowed Amount for the Covered Service that you receive. Please see "Inter-Plan Arrangement's" in the "Claims Procedure (How to File a Claim)" section for additional information.

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

- That meet our definition of Covered Services, to the extent such services and supplies are covered under your Booklet and are not excluded,
- That are Medically Necessary, and
- That are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in your Booklet.

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

*Surprise Billing Claims are described in the "Consolidated Appropriations Act of 2021 Notice" at the beginning of this Booklet. Please refer to that section for further details.

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 Provider 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 a special Centers of Medical Excellence/or 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 this Booklet 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 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.

For Covered Services you receive from an Out-of-Network Provider the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

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

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

For Covered Services rendered outside Anthem's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross 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 Anthem 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, or unless your claim involves a Surprise Billing Claim, an Out-of-Network Providers may send you a bill and collect for the amount of the Provider's charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing 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 this Booklet'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 Pharmacy Benefits Manager.

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).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether you received services from an In-Network or Out-of-Network Provider. Specifically, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the "Schedule of Benefits (Who Pays What)" in this Booklet for your cost share responsibilities and limitations, or call Member Services to learn how this Booklet's benefits or cost share amounts may vary by the type of Provider you use.

We will not provide any reimbursement for non-Covered Services. You may 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 Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

When you receive Covered Services for Emergency Care, usually the most you can be billed is your Plan's In-Network cost-sharing amounts, which are Copayments, Deductibles, and/or Coinsurance. You cannot be balanced-billed for any other amount. This includes both the Emergency Facility and any providers you may see for Emergency Care.

You have the right to request that In-Network Providers perform all Covered Services. If you receive Covered Services in an In-Network Provider Facility in Colorado from an Out-of-Network Provider, such as a radiologist, anesthesiologist or pathologist, and you did not knowingly choose the Out-of-Network Provider, you will pay the In-Network cost sharing levels for those Covered Services and will not have to pay the difference between the Out-of-Network Provider's charges and the Maximum Allowed Amount. The Facility must tell you if you are at an Out-of-Network or at an In-Network location that is using Out-of-Network Providers. The Facility must also tell you what types of services may be provided by any Out-of-Network Provider.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits (Who Pays What)" for your applicable amounts.

Example: Your Plan has a Coinsurance cost share of 20% for In-Network services, and 30% for Out-of-Network services after the In-Network or Out-of-Network Deductible has been met.

- *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. The Out-of-Network surgeon's charge for the service is $2500. The Maximum Allowed Amount for the surgery service is $1500; your Coinsurance responsibility for the Out-of-Network surgeon is 30% of $1500, or $450 after the Out-of-Network Deductible has been met. We allow the remaining 70% of $1500, or $1050. In addition, the Out-of-Network surgeon could bill you the difference between $2500 and $1500, so your total Out of Pocket charge would be $450 plus an additional $1000, for a total of $1450.*

Authorized Services

In some circumstances, such as where there is no In-Network Provider available, or if we don't have an In-Network Provider within a reasonable number of miles from your home, 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 circumstances, you must contact us in advance of obtaining the Covered Service. If approved, we will pay the Out-of-Network Provider at the In-Network level of benefits and you won't need to pay more for the services than if the services had been received from an In-Network Provider. A Precertification or preauthorization is not the same thing as an Authorized Service; we must specifically authorize the service from an Out-of-Network Provider at the In-Network cost share amounts.

Sometimes you may need to travel a reasonable distance to get care from an In-Network Provider. This does not apply if care is for an Emergency.

If you do not receive a preauthorized network exception to obtain Covered Services from an Out-of-Network Provider at the In-Network cost share amounts, the claim will be processed using your Out-of-Network cost shares unless your claim involves a Surprise Billing Claim.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet'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 in your state of residence. 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 Plan has a $45 Copayment for Out-of-Network Providers and 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 $475.

Federal/State Taxes/Surcharges/Fees

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

Claims Review

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse, and other inappropriate activity. Members seeking services from Out-of-Network Providers could be 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.

Section 10. Claims Procedure (How to File a Claim)

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

Notice of Claim & Proof of Loss

After you get Covered Services, we must receive written notice of your claim in order for benefits to be paid.

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

  Out-of-Network claims must be submitted within 180 days. In certain cases, state or federal law may allow additional time to file a claim, if you could not reasonably file within the 180-day period. The claim must have the information we need to determine benefits. If the claim does not include enough information, we will ask for more details and inform you of the time by which we need to receive that information. Once we receive the required information, we will process the claim according to the terms of your Plan.

Please note that failure to submit the information we need by the time listed in our request could result in the denial of your claim, unless state or federal law requires an extension. Please contact Member Services if you have any questions or concerns about how to submit claims.

Member's Cooperation

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments, and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate you will be responsible for any charge for services.

Payment of Benefits

You authorize us to make payments directly to Providers for Covered Services. In no event, however, shall our right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under the Plan. Where permitted by applicable law, we reserve the right to make payments directly to you as opposed to any Provider for Covered Service, at our discretion, except for claims for Emergency Care or Surprise Billing Claims for air ambulance services, or non-Emergency services performed by Out-of-Network Providers at certain In-Network

Facilities, which will be paid directly to Providers and Facilities. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the Group's Plan), or that person's custodial parent or designated representative. Any payments made by us (whether to any Provider for Covered Service or you) will discharge our obligation for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, we will not honor a request for us to withhold payment of the claims submitted.

The coverage, rights, and benefits under the Plan are not assignable by any Member without the written consent of the Plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the Plan and/or law, sue or otherwise begin legal action, or request Plan documents or any other information that a Participant or beneficiary may request under ERISA. Any assignment made without written consent from the Plan will be void and unenforceable.

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 "Anthem Service Area"), 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 Anthem Service Area, 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 ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

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 Anthem 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 Anthem 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. Nonparticipating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When Covered Services are provided outside of Anthem'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 or the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount we will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating 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. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the 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 800-810-2583. Or you can call them collect at 804-673-1177.

If you need inpatient hospital care, you, or someone on your behalf, should contact us for preauthorization. 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 "How to Access Your Services and Obtain Approval of Benefits" section in this Booklet for further information. You can learn how to get preauthorization when you need to be admitted to the hospital for Emergency or non-emergency care.

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.

Section 11. General Policy Provisions

Assignment

The Group cannot legally transfer this Booklet, without obtaining written permission from us. Members cannot legally transfer the coverage. Benefits available under this Booklet are not assignable by any Member without obtaining written permission from us, unless in a way described in the "How to Access Your Services and Obtain Approval of Benefits (Applicable to Managed Care Plans)" and in "Claims Procedure (How to File a Claim)" sections.

Automobile Insurance Provisions

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

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

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

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

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

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

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

Care Coordination

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

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, we will make a good-faith effort to ensure Covered Services are available to you. Circumstances that may occur, but are not within the control of the

Plan, include but are not limited to, a major disaster, epidemic, war, when health care services covered under this Plan are delayed or rendered impractical, or other events beyond our control. Under such circumstances, we will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Group or us.

Confidentiality and Release of Information

Applicable state and federal law require us to undertake efforts to safeguard your medical information.

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

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

Conformity with Law

Any term of the Plan which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

Contract with Anthem

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan constitutes a Contract solely between the Group and us, Anthem Blue Cross and Blue Shield (Anthem), and that we are an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Colorado. The Blue Cross Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, we are not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. The Group, on behalf of itself and its participants, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Blue Cross and Blue Shield (Anthem) and that no person, entity, or organization other than Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Group for any of Anthem Blue Cross and Blue Shield (Anthem's) obligations to the Group created under the Contract. This paragraph shall not create any additional obligations whatsoever on our part other than those obligations created under other terms of this agreement.

Entire Contract

Note: The laws of the state in which the Group Contract is issued will apply unless otherwise stated herein.

This Booklet or attachments, and the individual applications of the Subscriber and Dependents constitute the entire Contract between the Group and us and as of the Effective Date, supersede all other agreements. In addition, the Group has a Group Contract and Group Application which includes terms that apply to this coverage. Any and all statements made to us by the Group and any and all statements made to the Group by us are representations and not warranties. No such statement, unless it is contained in a written application for coverage under this Booklet, shall be used in defense to a claim under this Booklet.

Form or Content of Booklet

No agent or employee of ours is authorized to change the form or content of this Booklet. Changes can only be made through a written authorization, signed by an officer of Anthem. Changes are further noted in “Modifications” below this section.

Government Programs

The benefits under this Plan shall not duplicate any benefits that you are entitled to, or eligible for, under any other governmental program. This does not apply if any particular laws require us to be the primary payor. If we have duplicated such benefits, all money paid by such programs to you for services you have or are receiving, shall be returned by or on your behalf to us.

Medical Policy and Technology Assessment

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

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

Medicare

Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet terms, and federal law.

Except when federal law requires us to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Part B. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made payment for such services.

Modifications

This Booklet allows the Group to make Plan coverage available to eligible Members. However, this Booklet shall be subject to amendment, modification, and termination in accordance with any of its terms, the Group Contract, or by mutual agreement between the Group and us without the permission or involvement of any Member. Changes will not be effective until the date specified in the written notice we give to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms and conditions in this Booklet.

For employer groups of one to 100, if we amend this Booklet to change benefits, notice of the amendment will be given to the employer no less than 90 days before to the Effective Date of such change and the amendment(s) will be effective for each group on the renewal or anniversary date of the Group Contract.

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

Network Access Plan

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

Not Liable for Provider Acts or Omissions

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

Payment Innovation Programs

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

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

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

Policies, 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 Group Contract, 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 or behavioral health initiatives that may result in the payment of benefits not otherwise specified in this Booklet. We reserve the right to discontinue a pilot or test program at any time.

Program Incentives

We may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this Plan. 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, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue a program or an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Relationship of Parties (Group-Member-Anthem)

The Group is responsible for passing information to you. For example, if we give notice to the Group, it is the Group's responsibility to pass that information to you. The Group is also responsible for passing eligibility data to us in a timely manner. If the Group does not give us timely enrollment and termination information, we are not responsible for the payment of Covered Services for Members.

Relationship of Parties (Anthem and In-Network Providers)

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

Your health care Provider is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a Covered Service under this Plan. We shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by you while receiving care from any In-Network Provider or in any In-Network Provider's Facilities.

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

Reservation of Discretionary Authority

This section only applies when the interpretation of this Booklet is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

We, or anyone acting on our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, we, or anyone acting on our behalf, have complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental / Investigational, whether surgery is cosmetic, and whether charges are consistent with the Maximum Allowed Amount. However, a Member may utilize all applicable complaint and appeals procedures, and where required by applicable law, our determination may be reviewed de novo (as if for the first time) in a later appeal or legal action.

We, or anyone acting on our behalf, shall have all the powers necessary or appropriate to enable us to carry out the duties in connection with the operation and administration of the Plan. This includes, without limitation, the power to construe the Contract, to determine all questions arising under the Booklet and to make, establish and amend the rules, regulations, and procedures with regard to the interpretation and administration of the provisions of this Plan. However, these powers shall be exercised in such a manner that has reasonable relationship to the provisions of the Contract, the Booklet, Provider agreements, and applicable state or federal laws. A specific limitation or exclusion will override more general benefit language.

Right of Recovery and Adjustment

Whenever payment has been made in error, we will have the right to recover such payment from you or, if applicable, the Provider, or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

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

deduct or offset, including cross plan offsetting on In-Network claims and on Out-Of-Network claims where the Out-Of-Network Provider agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Unauthorized Use of Identification Card

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

Value-Added Programs

We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Value of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Workers' Compensation or Employer Liability Law, the value of Covered Services shall be the amount we paid for the Covered Services.

Voluntary Clinical Quality Programs

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

Voluntary Wellness Incentive Programs

We may offer health or fitness related program options for selection by your Group to help you achieve your best health. These programs are not Covered Services under your Plan, but are separate components, which are not guaranteed under this Plan and could be discontinued at any time. If your Group has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options a Group may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact us at the Member Services number on your ID card and we will work with you (and, if you wish, your Doctor) to find a wellness program with the same reward that is right for you in light of your health status. (If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Waiver

No agent or other person, except an authorized officer of Anthem, is able to disregard any conditions or restrictions contained in this Booklet, to extend the amount of time for making a payment to us, or to bind us by making any promise or representation or by giving or receiving any information.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers' Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by you, or on your behalf, to us if we have made or make payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Subrogation and Reimbursement

This section applies when we pay benefits as a result of injuries or illness and another party or party(ies) agrees or is ordered to pay money because of these injuries or when the Member received or is entitled to receive a recovery because of these injuries or illnesses. Recovery is money the Member, the Member's legal representative, or beneficiary receives whether by settlement, verdict, judgment, order or by some other monetary award or determination, from another, their insurer, or from any uninsured motorist, underinsured motorist, medical payments, personal injury protection, or any other insurance coverage, to compensate the Member as a result of bodily injury or illness to the Member. Regardless of how the Member, the Member's legal representative, or beneficiary or any agreement may characterize the money received, it shall be subject to this Subrogation and Reimbursement section of this Booklet.

Reimbursement or subrogation under this Booklet may only be permitted if you have been fully compensated, and, the amount recoverable by us may be reduced by a proportionate share of your attorney fees and costs, if state law so requires.

Subrogation

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

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

Reimbursement

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

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

- Notwithstanding any allocation made in a settlement agreement or court order, we shall have a right of reimbursement; and
- You, a person who represents your legal interest, or beneficiary must hold in trust for us right away the amount recovered in gross that is to be paid to us, and that amount must not be dissipated or spent until we have been repaid in accordance with these provisions. The amount recovered in gross is the total amount of your recovery reduced by your lawyer fees and costs.

The Member's Duties

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

Coordination of This Group Contract's Benefits With Other Benefits

This coordination of benefits (COB) provision applies when you have health care coverage under more than one Plan as defined below.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Booklet, e.g., Plan. For this provision only, "Plan" will have the meanings as specified below. In the rest of the Booklet, Plan has the meaning listed in the "Definitions" section.

The order-of-benefit determination rules determine the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may

reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. An Out-of-Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than Our Maximum Allowed Amount.

COB DEFINITIONS

A. **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   1) "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and any other federal governmental plan, as permitted by law.

   2) "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

      Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This Plan** means, in a COB provision, the part of the contract providing the health care benefits that the COB provision applies to and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determines whether This Plan is "Primary plan" or "Secondary plan" when you have health care coverage under more than one plan.

   When This Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When This Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary plan benefits, so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. **Allowable expense** is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense.

   The following are examples of non-Allowable expenses:

   1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses, or your stay is medically necessary in terms of generally accepted medical practice or the Hospital does not have a semi-private room.

   2. If you are covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary plan to determine its benefits.
5. The amount of any benefit reduction by the Primary plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.
6. The amount that is subject to the Primary high-deductible health plan's Deductible, if we have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

E. **Claim determination period** is usually a calendar year, but a Plan may use some other period of time that fits the coverage of the group contract. You are covered by a Plan during a portion of a claim determination period if your coverage starts or ends during the claim determination period. However, it does not include any part of a year during which you have no coverage under This Plan, or before the date this COB provision or a similar provision takes effect.

F. **Closed panel plan** is a Plan that provides health benefits to you primarily in the form of services through a panel of Providers that have contracted with either directly or indirectly or are employed by the Plan, and that limits or excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.

G. **Custodial parent** is the parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of payment are as follows:

1. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
2.
    1) Except as provided in paragraph 2) below, a Plan that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both Plans state that the complying Plan is primary.
    2) Coverage that is obtained by virtue of membership in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Out-of-Network benefits.
3. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
4. Pediatric Dental Coordination of Benefits (COB). These pediatric dental COB provisions are applicable to only the pediatric dental benefits found in the part titled Benefits/Coverage (What is Covered) in the section Pediatric Dental Covered Services. If pediatric dental Essential Health Benefits are included as part of the medical plan, the medical plan will be primary coverage and any

standalone dental plan will be secondary. If the member has two medical plans, each offering pediatric dental Essential Health Benefit coverage for spouse and family, the Order of Benefits Determinations rules apply.

5. Each Plan determines its order-of-benefits using the first of the following rules that apply:

    1) Non-Dependent or Dependent. The Plan that covers you as other than as a Dependent, for example as an employee, member, subscriber, or retiree is the Primary plan, and the plan that covers you as a Dependent is the Secondary plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent; and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order-of-benefits between the two Plans is reversed so that the Plan covering you as an employee, member, subscriber or retiree is the Secondary plan and the other plan is the Primary Plan.

    2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order-of-benefits is determined as follows:

        a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

            i. The Plan of the parent whose birthday (month and day) falls earlier in the calendar year is the Primary plan; or

            ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

        b. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

            i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree,

            ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of a, above shall determine the order-of-benefits,

            iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of a. above shall determine the order-of-benefits,

            iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

                a. The Plan covering the Custodial parent,

                b. The Plan covering the spouse of the Custodial parent,

                c. The Plan covering the non-custodial parent, and then

                d. The Plan covering the spouse of the non-custodial parent.

        c. For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of a. and b. above will determine the order-of-benefits as if those individuals were the parents of the child.

    3) Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering you as a retired or laid-off employee is the Secondary plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the

order-of-benefits, this rule is ignored. This rule does not apply if 5. 1) above can determine the order-of-benefits.

4) COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by state or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule for 5. 1) from above can determine the order of benefits.

5) Longer or Shorter Length of Coverage. The Plan that covers you as an employee, member, policyholder, subscriber, or retiree longer is the Primary plan and the plan that covers you for the shorter period of time is the Secondary plan.

6) If the preceding rules do not determine the order-of-benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of the other health care coverage.

B. If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We need not divulge, or get the consent of, any person to do this. Each person claiming benefits under this plan must give us any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by us is more than it should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Section 12. Termination/Nonrenewal/Continuation

Termination

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

- When the Contract between the Group and us terminates. If your coverage is through an association, your coverage will terminate when the Contract between the association and us terminates, or when your Group leaves the association. It will be the Group's responsibility to notify you of the termination of coverage.
- If you choose to terminate your coverage.
- If you or your Dependents cease to meet the eligibility requirements of the Plan, subject to any applicable continuation requirements. If you cease to be eligible, the Group and/or you must notify us immediately. The Group and/or you shall be responsible for payment for any services incurred by you after you cease to meet eligibility requirements.
- If you elect coverage under another carrier's health benefit plan, which is offered by the Group as an option instead of this Plan, subject to the consent of the Group. The Group agrees to immediately notify us that you have elected coverage elsewhere.
- If you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of your Plan, your coverage and the coverage of your Dependents can be retroactively terminated or rescinded. A rescission of coverage means that the coverage may be legally voided back to the start of your coverage under the Plan, just as if you never had coverage under the Plan. You will be provided with a 30-calendar day advance notice with appeal rights before your coverage is retroactively terminated or rescinded. You are responsible for paying us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayments made or Premium paid for such services.
- If you fail to pay or fail to make satisfactory arrangements to pay your portion of the Premium, we may terminate your coverage and may also terminate the coverage of your Dependents.
- If you permit the fraudulent use of your or any other Member's Plan Identification Card by any other person; use another person's Identification Card; or use an invalid Identification Card to obtain services, your coverage will terminate immediately upon our written notice to the Group. Anyone involved in the misuse of a Plan Identification Card will be liable to and must reimburse us for the Maximum Allowed Amount for services received through such misuse.
- If you are a partner to a civil union, recognized domestic partnership, or other relationship recognized as a spousal relationship in the state where the subscriber resides, on the date such union or relationship is revoked or terminated. Also, if there is coverage for designated beneficiaries, on the date a Recorded Designated Beneficiary Agreement is revoked or terminated. Where permitted by law, such a Dependent may be able to seek COBRA or state continuation coverage, subject to the terms of this Booklet.

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

Removal of Members

Upon written request through the Group, you may cancel your coverage and/or your Dependent's coverage from the Plan. If this happens, no benefits will be provided for Covered Services after the termination date even if we have preauthorized the service, unless the Provider confirmed eligibility within two business days before the service is received.

Continuation of Coverage Under Federal Law (COBRA)

The following applies if you are covered by a Group that is subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended.

COBRA continuation coverage can become available to you when you would otherwise lose coverage under your Group's health Plan. It can also become available to other Members of your family, who are covered under the Group's health Plan, when they would otherwise lose their health coverage. For additional information about your rights and duties under federal law, you should contact the Group.

Qualifying events for Continuation Coverage under Federal Law (COBRA)

COBRA continuation coverage is available when your coverage would otherwise end because of certain "qualifying events." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your Dependent children could become qualified beneficiaries if you were covered on the day before the qualifying event and your coverage would be lost because of the qualifying event. Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

This benefit entitles each Member of your family who is enrolled in the Plan to elect continuation independently. Each qualified beneficiary has the right to make independent benefit elections at the time of annual enrollment. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents or legal guardians may elect COBRA continuation coverage on behalf of their children. A child born to, or placed for adoption with, a covered Subscriber during the period of continuation coverage is also eligible for election of continuation coverage.

Qualifying Event	Length of Availability of Coverage
For Subscribers:	
Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
For Dependents:	
A Covered Subscriber's Voluntary or Involuntary Termination (other than gross misconduct) or Loss of Coverage Under an Employer's Health Plan Due to Reduction In Hours Worked	18 months
Covered Subscriber's Entitlement to Medicare	36 months
Divorce or Legal Separation	36 months
Death of a Covered Subscriber	36 months
For Dependent Children:	
Loss of Dependent Child Status	36 months

COBRA coverage will end before the end of the maximum continuation period listed above if you become entitled to Medicare benefits. In that case, a qualified beneficiary – other than the Medicare beneficiary – is entitled to continuation coverage for no more than a total of 36 months. (For example, if you become entitled to Medicare prior to termination of employment or reduction in hours, COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement.)

If Your Group Offers Retirement Coverage

If you are a retiree under this Plan, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Group, and that bankruptcy results in the loss of coverage, you will become a qualified beneficiary with respect to the bankruptcy. Your Dependents will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under this Plan. If COBRA coverage becomes available to a retiree and his or her covered family members as a result of a bankruptcy filing, the retiree may continue coverage for life and his or her

Dependents may also continue coverage for a maximum of up to 36 months following the date of the retiree's death.

Second qualifying event

If your family has another qualifying event (such as a legal separation, divorce, etc.) during the initial 18 months of COBRA continuation coverage, your Dependents can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the original qualifying event. Such additional coverage is only available if the second qualifying event would have caused your Dependents to lose coverage under the Plan had the first qualifying event not occurred.

Notification Requirements

The Group will offer COBRA continuation coverage to qualified beneficiaries only after the Group has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, commencement of a proceeding in bankruptcy with respect to the employer, or the Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Group will notify the COBRA Administrator (e.g., Human Resources or their external vendor) of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (e.g., divorce or legal separation of the Subscriber and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Group within 60 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

To continue your coverage, you or an eligible family Member must make an election within 60 days of the date your coverage would otherwise end, or the date the company's benefit Plan Administrator notifies you or your family Member of this right, whichever is later. You must pay the total Premium appropriate for the type of benefit coverage you choose to continue. If the Premium rate changes for active associates, your monthly Premium will also change. The Premium you must pay cannot be more than 102% of the Premium charged for Employees with similar coverage, and it must be paid to the company's benefit plan administrator within 30 days of the date due, except that the initial Premium payment must be made before 45 days after the initial election for continuation coverage, or your continuation rights will be forfeited.

Disability extension of 18-month period of continuation coverage

For Subscribers who are determined, at the time of the qualifying event, to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act, and Subscribers who become disabled during the first 60 days of COBRA continuation coverage, coverage may continue from 18 to 29 months. These Subscribers' Dependents are also eligible for the 18- to 29-month disability extension. (This also applies if any covered family Member is found to be disabled.) This would only apply if the qualified beneficiary gives notice of disability status within 60 days of the disabling determination. In these cases, the Employer can charge 150% of Premium for months 19 through 29. This would allow health coverage to be provided in the period between the end of 18 months and the time that Medicare begins coverage for the disabled at 29 months. (If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, such qualified beneficiary must notify the Plan Administrator of that fact in writing within 30 days after the Social Security Administration's determination.)

Trade Adjustment Act Eligible Individual

If you don't initially elect COBRA coverage and later become eligible for trade adjustment assistance under the U.S. Trade Act of 1974 due to the same event which caused you to be eligible initially for COBRA coverage under this Plan, you will be entitled to another 60-day period in which to elect COBRA coverage. This second 60-day period will commence on the first day of the month on which you become eligible for trade adjustment assistance. COBRA coverage elected during this second election period will be effective on the first day of the election period.

When COBRA Coverage Ends

COBRA benefits are available without proof of insurability and coverage will end on the earliest of the following:

- A covered individual reaches the end of the maximum coverage period,
- A covered individual fails to pay a required Premium on time,
- A covered individual becomes covered under any other group health plan after electing COBRA. If the other group health plan contains any exclusion or limitation on a pre-existing condition that applies to you, you may continue COBRA coverage only until these limitations cease,
- A covered individual becomes entitled to Medicare after electing COBRA, or
- The Group terminates all of its group welfare benefit plans.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Group's health Plan and your COBRA continuation coverage rights should be addressed to the Group. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Continuation of Coverage Under State Law

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

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

State Continuation Coverage Notification

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

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

When State Continuation Coverage Ends

Your state continuation coverage ends upon the earlier of the following:

- A covered individual reaches the end of the maximum coverage period,
- The Contract between us and your employer ends. If the employer gets other group coverage, continuation coverage will continue under the new plan,
- A covered individual fails to pay Premium timely,
- You are eligible for another group health plan unless the other plan does not cover something that is covered by the continuation coverage. In that case, the state continuation coverage lasts until the continuation period ends or the other plan covers the excluded condition,
- If you are covered as a Designated Beneficiary, on the date the Recorded Designated Beneficiary Agreement is revoked or terminated,
- The date the spouse remarries and becomes eligible for coverage under the new spouse's group health plan,
- You get Medicare or Medicaid, or
- You tell us in writing to cancel.

Continuation of Coverage Due To Military Service

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Subscriber or his / her Dependents may have a right to continue health care coverage under the Plan if the Subscriber must take a leave of absence from work due to military leave.

Employers must give a cumulative total of five years, and in certain instances, more than five years of military leave.

"Military service" means performance of duty on a voluntary or involuntary basis and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

During a military leave covered by USERRA, the law requires employers to continue to give coverage under this Plan to its Members. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for you (the individual on military leave) will be modified.

You may elect to continue to cover yourself and your eligible Dependents by notifying your employer in advance and submitting payment of any required contribution for health coverage. This may include the amount the employer normally pays on your behalf. If your military service is for a period of time less than 31 days, you may not be required to pay more than the active Member contribution, if any, for continuation of health coverage. For military leaves of 31 days or more, you may be required to pay up to 102% of the full cost of coverage, i.e., the employee and employer share.

The amount of time you continue coverage due to USERRA will reduce the amount of time you will be eligible to continue coverage under COBRA.

Maximum Period of Coverage During a Military Leave

Continued coverage under USERRA will end on the earlier of the following events:

1. The date you fail to return to work with the Group following completion of your military leave. Subscribers must return to work within:
    a) The first full business day after completing military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service,
    b) 14 days after completing military service for leaves of 31 to 180 days,
    c) 90 days after completing military service for leaves of more than 180 days, or

2. 24 months from the date your leave began.

Reinstatement of Coverage Following a Military Leave

Regardless of whether you continue coverage during your military leave, if you return to work your health coverage and that of your eligible Dependents will be reinstated under this Plan if you return within:

1. The first full business day of completing your military service, for leaves of 30 days or less. A reasonable amount of travel time will be allowed for returning from such military service,
2. 14 days of completing your military service for leaves of 31 to 180 days, or
3. 90 days of completing your military service for leaves of more than 180 days.

If, due to an illness or injury caused or aggravated by your military service, you cannot return to work within the time frames stated above, you may take up to:

1. Two years; or
2. As soon as reasonably possible if, for reasons beyond your control you cannot return within two years because you are recovering from such illness or injury.

If your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. Any waiting/probationary periods will apply only to the extent that they applied before.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not cover services for any illness or injury caused or aggravated by your military service, as indicated in the "Limitations/Exclusions (What is Not Covered)" section.

Family and Medical Leave Act of 1993

A Subscriber who takes a leave of absence under the Family and Medical Leave Act of 1993 (the Act) will still be eligible for this Plan during their leave. We will not consider the Subscriber and his or her Dependents ineligible because the Subscriber is not at work.

If the Subscriber ends their coverage during the leave, the Subscriber and any Dependents who were covered immediately before the leave may be added back to the Plan when the Subscriber returns to work without medical underwriting. To be added back to the Plan, the Group may have to give us evidence that the Family and Medical Leave Act applied to the Subscriber. We may require a copy of the health care Provider statement allowed by the Act.

Benefits After Termination Of Coverage

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

When your coverage ends for any reason other than for nonpayment of Premium, fraud or abuse, we will continue coverage if you are being treated at an inpatient facility, until you are discharged or transferred to another level of care. This is subject to the terms of this Booklet. The discharge date is seen as the first date on which you are discharged from the facility or transferred to another level of care. We will not cover the services you get after your discharge date.

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

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

Discontinuation of Coverage

We can refuse to renew your contract if we decide to discontinue a health coverage product that we offer in the small group market. If we discontinue a health coverage product, we will provide the policyholder 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 small group products in the state. In addition, your employer 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.

Section 13. Appeals and Complaints

We want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file a Grievance / Appeal, which is defined as follows:

We may have turned down your claim for benefits, your continuity of care request, or your request to cover a Drug as an exception to the Prescription Drug List. We may have also denied your request to preauthorize or receive a service or a supply. If you disagree with our decision you can:

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

Complaints

If you 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:

For medical and prescription drug or pharmacy issues:

Anthem Blue Cross and Blue Shield
Member Services Department
P.O. Box 17549
Denver, CO 80217-0549

For dental benefit issues:

Anthem Blue Cross and Blue Shield
P.O. Box 1122
Minneapolis, MN 55440

For vision benefit issues:

Anthem Blue Cross and Blue Shield / Blue View Vision
P.O. Box 9304
Minneapolis, MN 55440-9304

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

If we have denied a claim that you feel should have been covered, or handled in a different way, denied a request to cover a Drug as an exception to the Prescription Drug List, or had your coverage cancelled retroactively for a reason that is not because of your failure to pay premiums, you can file an appeal. You can appeal a denial that was made by us before the service is received. You can also appeal a denial on a service after it is received. You may also appeal an eligibility determination made by us.

If, after our denial, we consider, rely on, or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge. We will not base our appeal decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If we fail to follow the Appeal procedures outlined under this section the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

While we encourage you to file an appeal within 60 days of the unfavorable benefit determination, the written or oral appeal must be received by us within 180 days of the unfavorable benefit determination. We will assign an employee to help you in the appeal process. An appeal can be filed verbally by calling Member Services.

For medical and prescription drug or pharmacy issues:

Anthem Blue Cross and Blue Shield
Attn: Grievance and Appeals Department
700 Broadway
Denver, CO 80273

For dental benefit issues:

Anthem Blue Cross and Blue Shield
Attn: Grievance and Appeals Department
P.O. Box 1122
Minneapolis, MN 55440

For vision benefit issues:

Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance and Appeals Department
P.O. Box 9304
Minneapolis, MN 55440-9304

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

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

Internal Appeals

We have an internal process that we follow when reviewing your appeal. Members of our staff, who were not involved when your claim was first denied, will review the appeal. They may also talk with co-workers to assist in the review. For appeals of claims involving Utilization Review, you do not have the right to be present during the first internal appeal but are free to submit any documents or information that you want considered in your appeal.

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

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

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

Independent External Appeals

For claims based on Utilization Review, or a rescission or retroactive cancellation of coverage for reasons other than nonpayment 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 appeal. Utilization Review includes claims we denied as Experimental or Investigational or not Medically Necessary. It also includes claims

where we reviewed your medical circumstances to decide if an exclusion applied. For these appeals, your case is reviewed by an external review entity, selected by the Colorado Division of Insurance. There is no minimum dollar amount for a claim to be eligible for an external review.

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

Expedited external appeal – You or your representative can request an expedited independent external review, but only in certain cases:

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

If it meets these conditions, your request for an expedited external appeal can be filed at the same time as your request for an expedited internal appeal. There is no minimum dollar amount for a claim to be eligible for an external review.

Grievances

If you have an issue or concern about the quality or services you receive from an In-Network Provider or Facility, you can file a grievance. The quality management department strives to resolve grievances fairly and quickly.

For medical and prescription drug or pharmacy issues:

Anthem Blue Cross and Blue Shield
Attn: Grievance and Appeals Department
700 Broadway
Denver, CO 80273-0001

For dental benefit issues:

Anthem Blue Cross and Blue Shield
Attn: Grievance and Appeals Department
P.O. Box 1122
Minneapolis, MN 55440

For vision benefit issues:

Anthem Blue Cross and Blue Shield / Blue View Vision
Attn: Grievance and Appeals Department
P.O. Box 9304
Minneapolis, MN 55440-9304

Our quality management department will acknowledge that we've received your grievance. They'll also investigate it. We treat every grievance confidentially.

Division of Insurance Inquiries

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

Binding Arbitration

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

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced no earlier than 60 days after we receive the claim or other request for benefits and within three years of our final decision on the claim or other request for benefits. If we decide an appeal is untimely, our latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust our internal appeals process before filing a lawsuit or other legal action of any kind against us. 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. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA within one year of the grievance or appeal decision.

Prescription Drug List Exceptions

Please refer to the "Prescription Drug List" section in "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for the process to submit 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 you and/or the Group must pay us to get coverage. We figure out and set the required Premiums.

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

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

Section 15. Definitions

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Member Services at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability, or similar law.

Ambulatory Surgery Center

A facility licensed as an Ambulatory Surgery Center as required by law that must satisfy our accreditation requirements and be approved by us.

Applied Behavioral Analysis

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

Approved In-Network Provider

Please see the "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services" benefit in the "Benefits/Coverage (What is Covered)" section.

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will not have to pay any more than the In-Network Deductible, Coinsurance, and/or Copayment(s) that apply. Please see the "Claims Procedure (How to File a Claim)" section as well as the "Consolidated Appropriations Act of 2021 Notice" at the beginning of this Booklet for more details.

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 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 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

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your Group's effective or renewal date and lasts for 12 months. (See your Group for details.) The "Schedule of Benefits (Who Pays What)" shows if your Plan's Benefit Period is a Calendar Year or a Plan Year. If your coverage ends before the end of the year, then your Benefit Period also ends.

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Biosimilar/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 differences from the reference product.

Booklet

This document (also called the certificate), which describes the terms of your benefits. It is part of the Group Contract with your Employer and is also subject to the terms of the Group Contract.

Brand Name Drugs

Prescription Drugs that we classify as Brand Drugs or that our PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Medical Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Centers of Medical Excellence Agreement with us.

Chiropractic Care / Manipulative Therapy

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

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is $100, your Coinsurance would be $20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. See the “Schedule of Benefits (Who Pays What)” for details. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments (except as described in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section).

Complications of Pregnancy

Complications of Pregnancy means:

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

Congenital Defect

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

Consolidated Appropriations Act of 2021

Please refer to the “Consolidated Appropriations Act of 2021 Notice” at the beginning of this Booklet for details.

Controlled Substances

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

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a $15 Copayment for an office visit, but a $150 Copayment for Emergency Room Services. See the “Schedule of Benefits (Who Pays What)” for details. Your Copayment will be the lesser of the amount shown in the “Schedule of Benefits (Who Pays What)" or the Maximum Allowed Amount.

Covered Procedure

Please see the “Human Organ and Tissue Transplant (Bone Marrow / Stem Cell), Cellular and Gene Therapy Services” benefit in the “Benefits/Coverage (What is Covered)” section for details.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider’s license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

Covered Services do not include services or supplies not described in the Provider records.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,
- Changing dressings of non-infected wounds, after surgery or chronic conditions,
- Preparing meals and/or special diets,
- Feeding by utensil, tube, or gastrostomy,
- Common skin and nail care,
- Supervising medicine that you can take yourself,
- Catheter care, general colostomy, or ileostomy care,
- Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
- Residential care and adult day care,
- Protective and supportive care, including education,
- Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is $1,000, your Plan won't cover anything until you meet the $1,000 Deductible. The Deductible may not apply to all Covered Services. Please see the "Schedule of Benefits (Who Pays What)" for details.

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 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 Services (All Members / All Ages) description.

Dependent

A member of the Subscriber's family who meets the rules listed in the "Eligibility" section and who has enrolled in the Plan.

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.

Doctor

See the definition of "Physician."

Early Intervention Services

Services, as defined by Colorado law in accordance with part C, that are authorized through an Eligible Child's IFSP but that exclude: nonemergency medical transportation; respite care; service coordination, as defined in federal law; and assistive technology (unless covered under this Booklet as durable medical equipment).

- Eligible Child – means an infant or toddler, from birth through two years of age, who is an eligible Dependent and who, as defined by Colorado law, has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for services pursuant to Colorado law.
- Individualized family service plan or IFSP – means a written plan developed pursuant to federal law that authorizes early intervention services to an Eligible Child and the child's family. An IFSP shall serve as the individualized plan for an Eligible Child from birth through two years of age.

Effective Date

The date your coverage begins under this Plan.

Emergency (Emergency Medical Condition)

Please see the "Benefits/Coverage (What is Covered)" section.

Emergency Care

Please see the "Benefits/Coverage (What is Covered)" section.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

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

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

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

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

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

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

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

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

- The written protocol(s) used by the treating Physicians, other medical professionals or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply,
- Medical records, or
- The opinions of consulting Providers and other experts in the field.

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

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgery Center, Residential Treatment Center, or Skilled Nursing Facility as defined in this Booklet. The Facility must be licensed as required by law, satisfy our accreditation requirements, and be approved by us.

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 Name Drug.

Group

The employer or other organization (e.g., association), which has a Group Contract with us, Anthem for this Plan.

Group Contract (or Contract)

The Contract between us, Anthem, and the Group (also known as the Group Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, and any legal terms added by us to the original Contract.

The Group Master Contract is kept on file by the Group. If a conflict occurs between the Group Master Contract and this Booklet, the Group Master Contract controls.

Habilitative Services

Habilitative Services help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age.

Home Health Care Agency

A Provider licensed when required by law and approved by us, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

A Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient's Doctor. It must be licensed by the appropriate agency.

Hospital

A facility licensed as a Hospital as required by law that must satisfy our accreditation requirements and be approved by us. 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)

The card we give you that shows your Member identification, Group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements. A Provider that is In-Network for one plan may not be In-Network for another. Please see “How to Find a Provider in the Network” in the section “How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)” for more information on how to find an In-Network Provider for this Plan.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive In-Home Behavioral Health Services

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders that provides a combination of individual, group and family therapy to Members who require a type or frequency of treatment that is not available in a standard outpatient setting.

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, it is expected to produce the same clinical result as the reference product in any given patient.

Late Enrollees

Subscribers or Dependents who enroll in the Plan after the initial enrollment period. A person will not be considered a Late Enrollee if he or she enrolls during a Special Enrollment period. Please see the “Eligibility” section for further details.

Maintenance Medications

Please see the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section for details.

Maintenance Pharmacy

An In-Network Retail Pharmacy that is contracted with our PBM to dispense a 90-day supply of Maintenance Medication.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the “Member Payment Responsibility” section.

Medical Necessity (Medically Necessary)

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

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

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

Member

People, including the Subscriber and his or her Dependents, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

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

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

Open Enrollment

A period of time in which eligible people or their dependents can enroll without penalty after the initial enrollment. See the "Eligibility" section for more details.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

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

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does *not* include your Premium, amounts over the Maximum Allowed Amount, or charges for health care that your Plan doesn't cover. Please see the "Schedule of Benefits (Who Pays What)" for details.

Partial Hospitalization Program

Structured, multidisciplinary treatment for Mental Health and Substance Use Disorders, including nursing care and active individual, group and family treatment for Members who require more care than is available in an Intensive Outpatient Program.

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

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization 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 Anthem's behalf. Anthem's PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

The management and other services the PBM provide include but are not limited to: managing a network of Retail Pharmacies and operating a mail service Pharmacy. Anthem's PBM, in consultation with Anthem, 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.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor,
- Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and
- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan

The benefit plan your Group has purchased, which is described in this Booklet.

Precertification

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

Premium

The amount that you and/or the Group must pay to be covered by this Plan. This may be based on your age and will depend on the Group's Contract with us.

Prescription Drug (Drug)

A substance, that under the Federal Food, Drug & Cosmetic Act, must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, when all of the ingredients are FDA approved, require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer.
- Insulin, diabetic supplies, and syringes.

Prescription Order

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

Primary Care Physician / Provider ("PCP")

A Provider who gives or directs health care services for you. The Provider may work in family practice, general practice, internal medicine, pediatrics, or any other practice allowed by the Plan. A PCP supervises, directs, and gives initial care and basic medical services to you and is in charge of your ongoing care.

Provider

A professional or Facility licensed when required by law that gives health care services within the scope of that license, must satisfy our accreditation requirements and be approved by us. Details on our accreditation requirements can be found at https://www.anthem.com/provider/credentialing/. This includes any Provider that state law says we must cover when they give you Covered Services. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider not described in this Booklet, please call the number on the back of your Identification Card.

Qualified Early Intervention Service Provider

Means a person or agency, as defined by Colorado law in accordance with part C, who provides Early Intervention Services and is listed on the registry of early intervention service providers.

Qualifying Payment Amount

The median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services.

Recognized Amount

For Surprise Billing Claims, the Recognized Amount is calculated as follows:

- For Air Ambulance services, the Recognized Amount is equal to the lesser of the Qualifying Payment Amount as determined under applicable law (generally, the median Plan In-Network contract rate we pay In-Network Providers for the geographic area where the service is provided for the same or similar services) or the amount billed by the Out-of-Network Air Ambulance service provider.
- For all other Surprise Billing Claims, the Recognized Amount is the amount determined by a specified state law, the lesser of the Qualifying Payment Amount or the amount billed by the Out-of-Network

Provider or Out-of-Network Facility, or the amount approved under an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.

Referral

Please see the “How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)” section for details.

Residential Treatment Center / Facility

An Inpatient Facility that provides multidisciplinary treatment for Mental Health and Substance Use Disorder conditions. The Facility must be licensed as a residential treatment center in the state in which it is located, satisfy our accreditation requirements, and be approved by us.

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

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Skilled Nursing Facility

An Inpatient Facility that provides multidisciplinary treatment for convalescent and rehabilitative care. It must be licensed as a skilled nursing facility in the state in which it is located, satisfy our accreditation requirements and be approved by us.

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.

Special Enrollment

A period of time in which eligible people or their dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility” section for more details.

Specialist (Specialty Care Physician \ Provider or SCP)

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

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Subscriber

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

Surprise Billing Claim

Please refer to the “Consolidated Appropriations Act of 2021 Notice” at the beginning of this Booklet for details.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Review

A set of formal techniques to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, care management, discharge planning and/or retrospective review. Utilization Review also includes reviewing whether or not a procedure or treatment is considered Experimental or Investigational, and reviewing your medical circumstances when such a review is needed to determine if an exclusion applies.

End of Booklet

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone 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 vl có quyЛn nhұn miHn phí thông tin này và sӧ trö giúp bʇng ngôn ngӳ cёa quý vl. Hãy gäi cho sæ Dlch Vө Thành Viên trên thẹ ID cёa quý vl ўЬ ўиӧc giúp ўй. (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 bezpáatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim jĊzyku. W tym celu skontaktuj siĊ z Dziaáem Obsáugi 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)

It's important we treat you fairly
We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. 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 in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.