

A Guide to Your Benefits

*You've made a good decision in choosing
BlueAdvantage HMO and Point of Service Rider*

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CM23-0411

**Colorado Health Benefit Plan Description Form
HMO Colorado / Anthem Blue Cross and Blue Shield
BlueAdvantage Point-of-Service (POS) Plan No. 15-4-15/30/45/30%-P500
Effective January 1, 2011**

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Point of service (i.e., an HMO plan with some out-of-network benefits)
2. OUT-OF-NETWORK CARE COVERED? ¹	Yes, but the patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

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

	IN-NETWORK	OUT-OF-NETWORK
4. Deductible Type²	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE^{2a}		
a) Individual^{2b}	No deductible	\$500
b) Family^{2c}	No deductible	\$1,000 aggregate
		Some covered services have a maximum benefit of days, visits or dollar amounts . When the deductible is applied to a covered service which has a maximum number of days or visits, those maximum benefits will be reduced by the amount applied toward the deductible, whether or not the covered service is paid.

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

	IN-NETWORK	OUT-OF-NETWORK
5. OUT-OF-POCKET ANNUAL MAXIMUM³ a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	\$2,000 \$4,000 Copayments for inpatient hospital, outpatient/ambulatory surgery and other outpatient services except emergency room copayments apply to the out-of-pocket annual maximum. All other copayments including but not limited to PCP or specialties copayments are still required after the out-of-pocket annual maximum is met. Not applicable Some covered services have a maximum numbers of days, visits or dollar amounts allowed during a calendar year. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied.	\$2,500 + Deductible \$5,000 + Deductible No Some covered services have a maximum numbers of days, visits or dollar amounts allowed during a calendar year. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied. The difference between billed charges and the maximum allowed amount for non-participating providers does not count toward the out-of-pocket annual maximum. Even once the out-of-pocket annual maximum is satisfied, the member will still be responsible for paying the difference between the maximum allowed amount and the non-participating providers billed charges.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum for most covered services. Infertility diagnostic services have a lifetime maximum payment of \$2,000 per member. Bariatric surgery has a per occurrence maximum payment of \$15,000 per member for services received from a designated facility (and \$1,500 per member from a facility that is not a designated facility) with a total per occurrence maximum that shall not exceed \$15,000 per member for designated and non-designated facilities combined.	No lifetime maximum for most covered services. Infertility diagnostic services are not covered out of network. Bariatric surgery has a per occurrence maximum payment of \$1,500 per member from a facility that is not a designated facility with a total per occurrence maximum that shall not exceed \$15,000 per member for designated and non-designated facilities combined.
7A. COVERED PROVIDERS	HMO Colorado Managed Care Network. See provider directory for complete list of current providers.	All providers licensed or certified to provide covered benefits.

	IN-NETWORK	OUT-OF-NETWORK
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes
8. MEDICAL OFFICE VISITS⁴ a) Primary Care Providers b) Specialists	\$15 copayment per visit \$15 copayment per visit	Covered person pays 30% after deductible Covered person pays 30% after deductible
9. PREVENTIVE CARE a) Children's services b) Adults' services	No copayment (100% covered) No copayment (100% covered) Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations and office visits.	Up to age 13, covered person pays \$30 copayment per visit. Copayment includes services provided as preventive care. \$30 copayment per visit. Copayment includes services provided as preventive care. For covered colonoscopy facility services, covered person pays \$500 copayment. Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations and office visits.
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care⁵	One time \$15 copayment for first prenatal care visit office visit and delivery from the physician. \$400 per admission copayment	Covered person pays 30% after deductible Covered person pays 30% after deductible
11. PRESCRIPTION DRUGS Level of coverage & restrictions on prescriptions⁶ a) Inpatient care b) Outpatient care	Included with the inpatient hospital benefit (see line 12) Retail Pharmacy Drugs - Tier 1 \$15 copayment, tier 2 \$30 copayment, tier 3 \$45 copayment, tier 4 30% coinsurance, per prescription at a participating pharmacy up to a 30-day supply. For tier 4 retail pharmacy drugs, the maximum copayment per prescription is \$100 per 30-day supply. Specialty Pharmacy Drugs - Tier 1 \$15 copayment, tier 2 \$30 copayment, tier 3 \$45 copayment, tier 4 30% coinsurance per prescription from our Specialty Pharmacy up to a 30-day supply.	Included with the inpatient hospital benefit (see line 12) Not covered Not covered

	IN-NETWORK	OUT-OF-NETWORK
c) Prescription Mail Service	<p>For tier 4 Specialty Pharmacy Drugs the maximum copayment per prescription is \$100 per 30-day supply from our Specialty Pharmacy. Specialty Pharmacy Drugs are not available at a retail pharmacy or from a mail-order pharmacy. Specialty pharmacy drugs are only available through the Pharmacy Benefit Manager (PBM).</p> <p>Mail-Order Pharmacy Drugs - Tier 1 \$30 copayment, tier 2 \$60 copayment, tier 3 \$90 copayment, tier 4 30% coinsurance, per prescription through the mail-order service up to a 90-day supply. For the tier 4 mail-order drugs, the maximum copayment per prescription is \$100 per 30-day supply or \$200 per 90-day supply. Specialty pharmacy drugs are only available through the Pharmacy Benefit Manager (PBM).</p> <p>The following applies to b) and c) above: Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem.</p> <p>Asthma and diabetic prescription drugs and supplies received from a retail pharmacy or mail-order pharmacy are covered under the tier 1 copayment.</p> <p>Prescription Drugs will always be dispensed as ordered by your provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket expenses. You may request, or your provider may order, the brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and brand-name drug, in addition to your tier 1 generic copayment. The cost difference between the generic and brand-name drug does not contribute the out-of-pocket annual maximum. By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness. HMO Colorado reserves the right, at our discretion, to remove certain higher cost generic drugs from this policy. For drugs on our approved list, call customer service at 800-542-9402.</p>	<p>Not covered</p> <p>Not covered</p>

	IN-NETWORK	OUT-OF-NETWORK
12. INPATIENT HOSPITAL	\$400 copayment per admission	Covered person pays 30% after deductible
13. OUTPATIENT/AMBULATORY SURGERY	\$75 copayment per procedure	Covered person pays 30% after deductible
14. DIAGNOSTICS		
a) Laboratory & x-ray	\$15 copayment per visit (waived if part of a medical office visit)	Covered person pays 30% after deductible
b) MRI, nuclear medicine, and other high-tech services	\$100 copayment per procedure for MRI/MRA/CT/PET scans	Covered person pays 30% after deductible
15. EMERGENCY CARE^{7,8}	\$100 copayment per emergency room visit (waived if admitted)	Out-of-network care is paid as in-network
16. AMBULANCE	\$100 copayment per trip (waived if admitted)	Out-of-network care is paid as in-network
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	\$50 copayment per urgent care visit. Urgent care may be received from your PCP or from an urgent care center.	\$50 copayment per urgent care visit. Urgent care may be received from your PCP or from an urgent care center.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE⁹		
a) Inpatient care	\$400 copayment per admission	Covered person pays 30% after deductible
b) Outpatient care	For outpatient facility services covered person pays no copayment (100% covered); for outpatient office visits and professional services \$15 copayment per visit for PCP or specialists.	Covered person pays 30% after deductible
20. ALCOHOL AND SUBSTANCE ABUSE		
a) Inpatient care	\$400 per admission copayment	Covered person pays 30% after deductible
b) Outpatient care	For outpatient facility services covered person pays no copayment (100% covered); for outpatient office visits and professional services \$15 copayment per visit for PCP or specialists.	Covered person pays 30% after deductible
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY		
a) Inpatient	\$400 copayment per admission. Limited to 30 non-acute inpatient days per calendar year in- and out-of-network combined.	Covered person pays 30% after deductible. Limited to 30 non-acute inpatient days per calendar year in- and out-of-network combined.
b) Outpatient	\$15 copayment per visit. Limited to 30 visits per calendar year each for physical, occupational and speech therapy in- and out-of-network combined. From birth until the member's sixth birthday benefits are provided as required by applicable law.	Covered person pays 30% after deductible. Limited to 30 visits per calendar year each for physical, occupational and speech therapy in- and out-of-network combined. From birth until the member's sixth birthday benefits are provided as required by applicable law.

	IN-NETWORK	OUT-OF-NETWORK
22. DURABLE MEDICAL EQUIPMENT	No copayment (100% covered).	Covered person pays 30% after deductible.
23. OXYGEN	No copayment (100% covered).	Covered person 30% after deductible
24. ORGAN TRANSPLANTS a) Inpatient b) Outpatient	\$400 per admission copayment \$15 per visit copayment Transportation and lodging services are limited to a maximum benefit of \$10,000; unrelated donor searches are limited to a maximum benefit of \$30,000.	Covered by HMO Colorado when preauthorized and delivered at a Center of Excellence. Covered person pays 30% after deductible. Transportation and lodging services are limited to a maximum benefit of \$10,000; unrelated donor searches are limited to a maximum benefit of \$30,000.
25. HOME HEALTH CARE	No copayment (100% covered)	Covered person 30% after deductible
26. HOSPICE CARE	No copayment (100% covered)	Covered person 30% after deductible
27. SKILLED NURSING FACILITY CARE	No copayment (100% covered). Limited to 60 days per calendar year combined in- and out-of-network.	Covered person 30% after deductible. Limited to 60 days per calendar year combined in- and out-of-network.
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Not covered	Not covered
30. CHIROPRACTIC CARE	\$15 per visit copayment . Limited to 20 visits per calendar year combined with out-of-network coverage for chiropractic care, in-network coverage for massage therapy and in-network coverage with acupuncture care	Covered person 30% after deductible. Limited to 20 visits per calendar year combined with in-network coverage for chiropractic care, in-network coverage for massage therapy and in-network coverage for acupuncture.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	BlueCares for You Program Second Opinions When a member desires another professional opinion, they may obtain a second opinion. Hearing Aids For hearing aids no copayment (100% covered). Benefits are covered up to age 18 and are supplied every 5 years, except as required by law. Massage Therapy/Acupuncture Care \$15 copayment per visit. Limited to 20 visits per calendar year combined with in and out-of-network coverage for chiropractic care and in-network coverage for acupuncture care and massage therapy.	For services covered under this rider, a member is not required to get a PCP referral. A member may also choose to receive covered services from a provider who is not in the HMO Colorado network. Second Opinions When a member desires another professional opinion, they may obtain a second opinion. Hearing Aids For hearing aids no copayment (100% covered). Benefits are covered up to age 18 and are supplied every 5 years, except as required by law. Massage Therapy/Acupuncture Care Not covered

	IN-NETWORK	OUT-OF-NETWORK
	<p>Treatment of Autism Spectrum Disorders Benefit level determined by type of service provided.</p> <p>The following annual maximums, based on calendar year, are effective for applied analysis services for in- and out-of-network services combined:</p> <ul style="list-style-type: none"> • From birth to age eight (up to member's ninth birthday): \$34,000 in and out-of-network combined • Age nine to age eighteen (up to member's nineteenth birthday): \$12,000 in and out-of-network combined 	<p>Treatment of Autism Spectrum Disorders Benefit level determined by type of service provided.</p> <p>The following annual maximums, based on calendar year, are effective for applied analysis services for in- and out-of-network services combined:</p> <ul style="list-style-type: none"> • From birth to age eight (up to member's ninth birthday): \$34,000 in and out-of-network combined • Age nine to age eighteen (up to member's nineteenth birthday): \$12,000 in and out-of-network combined

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. ¹⁰	Not applicable; plan does not impose limitation periods for pre-existing conditions. For late enrollees, individual must wait until next open enrollment.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable. Plan does not exclude coverage for pre-existing conditions
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan, sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining the pre-certification.	Yes, the member is responsible for obtaining pre-certification unless the provider participates with Anthem Blue Cross and Blue Shield.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
39. What is the main customer service number?	800-542-9402	
40. Whom do I write/call if I have a complaint or want to file a grievance? ¹¹	HMO Colorado, Complaints and Appeals 700 Broadway, CAT0430, Denver, CO 80273 800-542-9402	

	IN-NETWORK	OUT-OF-NETWORK
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form #'s 98898_GF Group – Large group only	
43. Does the plan have a binding arbitration clause?	Yes	

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a physician and/or licensed, certified or registered provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost).
- Not experimental/investigational.
- Not primarily for the convenience of the member, the member's family or the provider.
- Not otherwise subject to an exclusion under the Certificate.

The fact that a physician and/or provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies medically necessary.

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

Small employers purchasing any health benefit plan other than the Colorado Basic Limited Mandate Health Benefit Plan must pay for all of the mandated benefits pursuant to section 10-16-104, C.R.S. The premium for this plan includes the cost of these mandated benefits, specifically: coverages for newborn, maternity, pregnancy, childbirth, complications from pregnancy and childbirth, therapies for congenital defects and birth abnormalities, low-dose mammography, mental illness, biologically-based mental illness, the availability of alcoholism treatment, the availability of hospice care, prostate cancer screening, child health supervision, hospitalization and general anesthesia for dental procedures for dependent children, diabetes, prosthetic devices, early intervention services for certain children, colorectal screening, cervical cancer vaccinations, and certain routine care during participation in a clinical trial. Pursuant to Colorado law (C.R.S. §10-16-105(5)(g)(I)), small employers purchasing any health benefit plan other than a Basic Health Benefit Plan, must pay for all benefits mandated by Colorado law, including nonwaivable coverages for: newborn, maternity, pregnancy, childbirth, complications from pregnancy and childbirth, therapies for congenital defects and birth abnormalities, low-dose mammography, mental illness, biologically-based mental illness, the availability of alcoholism treatment, the availability of hospice care, prostate cancer screening, child health supervision services, hospitalization and general anesthesia for dental procedures for dependent children, diabetes, and prosthetic devices.

For those enrolled on the Colorado Basic Limited Mandate Health Benefit Plan:

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

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

1. **Non-payment of the required premium;**
2. **Fraud or intentional misrepresentation of material fact on the part of the plan sponsor;**
3. **The policyholder fails to comply with participation or contribution rules;**
4. **The carrier elects to discontinue offering and non-renew all of its small group or large group plans delivered or issued for delivery in Colorado;**
5. **An employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan;**
6. **With respect to group health benefit plans offered through a managed care plan, there are no longer any enrollees who live, reside or work in the service area; or**
7. **With respect to coverage of an employer that is made available only through one or more bona fide associations, the membership of an employer ceases.**

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

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

Grandfathered Health Plan

Anthem Blue Cross and Blue Shield and HMO Colorado believes this is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered plan means that your Certificate may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

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 one routine screening or diagnostic mammogram per year regardless of age (or in accordance with the frequency determined by your provider) for women. Payment for the mammogram screening benefit is based on the plan's provisions for preventive care and is normally not subject to the deductible or coinsurance.

Prostate Cancer Screenings

All plans except our HMO and PPO Basic Health Plans provide coverage under the preventive care benefits for one routine prostate cancer screening per year regardless of age (or in accordance with the frequency determined by your provider) for men. Payment for the prostate cancer screening is based on the plan's provisions for preventive exam and laboratory services and is normally not subject to the deductible or coinsurance.

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 are not subject to the deductible or coinsurance.

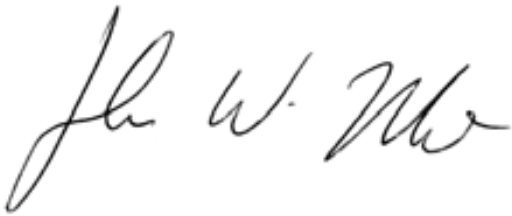
The information above is only a summary of the benefits described. The certificate for each health plan includes important additional information about limitations, exclusions and covered benefits. The Colorado Health Benefit Plan Description Form for each health plan includes additional information about copayments, deductibles and coinsurance. If you have any questions, please call our customer service department at the phone number on the Colorado Health Benefit Plan Description Form.

Point-of-Service Rider to BlueAdvantage HMO Certificate

Your BlueAdvantage HMO Certificate is hereby amended in accordance with the Group Master Contract issued by HMO Colorado (HMOC) to your employer to include this Point-of-Service Rider. The benefits of this rider are underwritten by HMO Colorado and are subject to all provisions of the BlueAdvantage HMO Certificate unless otherwise stated.

This rider is effective on the date it is incorporated into your employer's Group Master Contract or your effective date of coverage, whichever is later.

Sincerely,

A handwritten signature in black ink, appearing to read "John W. Martie". The signature is written in a cursive style with a large initial "J" and "M".

John Martie
President and General Manager
HMO Colorado

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

Your Point-of-Service Rider at a Glance

This Point-of-Service Rider is designed to give you the choice of receiving Covered Services outside of your BlueAdvantage HMO Plan requirements. For services covered under this rider, you may obtain services from Out-of-Network Providers. In other words, the member chooses the level of coverage received at the “point of service.” This BlueAdvantage Point-of-Service Rider does not restrict or interfere with the right of any member entitled to service and care in a hospital to select a hospital or to choose an attending physician.

If a member obtains nonemergency services from Out-of-Network Providers, Medically Necessary services may be available as “point-of-service” benefits under this rider, subject to Deductible and Coinsurance specified on the *Health Benefit Plan Description Form*. Note: Many Covered Services require Preauthorization. See the **HOW THE POINT-OF-SERVICE RIDER WORKS** for details on Preauthorization requirements.

Not all Covered Services that are described in the BlueAdvantage HMO Certificate are covered under this rider. See this rider's **GENERAL EXCLUSIONS** section for a list of services that are not covered.

When you have questions or concerns, customer service wants to know. Your comments and suggestions are welcome. Listening to you helps improve customer service. Your customer service representative is knowledgeable about your point-of-service Covered Services, procedures, and Providers. Please have your Health Benefit ID Card handy when calling a customer service representative. The website address and local and toll-free customer service department numbers located on your *Health Benefit Plan Description Form* or Health Benefit ID Card.

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How to Use this Point-of-Service Rider

When Services Are Covered Under This Rider

This Point-of-Service Rider provides coverage for certain services that are not obtained in accordance with the rules and procedures of the BlueAdvantage HMO Certificate. All provisions of your BlueAdvantage HMO Certificate are used to determine whether services are covered under this rider, unless specifically addressed in this rider. You will receive the most comprehensive level of coverage by following the procedures outlined in the BlueAdvantage HMO Certificate.

If you receive services that are not provided by an In-Network Provider or that are provided without Our Authorization, these services may be eligible for coverage under this rider. Covered services under this rider are subject to a Members Benefit Period Deductible and Coinsurance unless otherwise specified in this rider or in the *Health Benefit Plan Description Form*. Also, not all services that are covered by the BlueAdvantage HMO Certificate are covered under this rider.

Preauthorization Required

For certain services covered under this rider and for all Inpatient admissions, you or your Provider are required to obtain Preauthorization from Us. We will indicate when Covered Services require Preauthorization.

How the Point-of-Service Rider Works

When you enroll in the BlueAdvantage HMO Plan, you must choose a Primary Care Physician (PCP) for each covered member of your family. If an In-Network Provider provides care for Covered Services, you receive full BlueAdvantage HMO Plan benefits, according to the terms of the BlueAdvantage HMO Certificate. Emergency Care and Urgent Care are covered at the In-Network level.

Services Not Covered Under This Rider

Some services covered under the BlueAdvantage HMO Certificate are not covered under this rider.

Point-of-Service Provider Choices

Point-of-Service Providers (physicians, hospitals, and other health care facilities and professionals) may have a Participating Provider agreement or no agreement with Us. Those with no agreement are referred to as Non-Participating Providers.

With this BlueAdvantage Point-of-Service Rider, you have the flexibility to choose Providers that are either inside or outside Our Participating Provider network. However, you can reduce your out-of-pocket expenses by using Participating Providers.

Participating Providers

Participating Providers have entered into a network agreement with Us for this specific health benefit program. When you visit a Participating Provider you have lower out-of-pocket expenses. Your Out-Network Cost Sharing responsibilities to Participating Providers may be found on the *Health Benefit Plan Description Form* under the “Out-of-Network” heading. You are responsible for determining if your Provider is a Participating Provider. You may visit Our website or call Our customer service department for Provider information.

We make no guarantee that a Participating Provider will be available for all services and supplies covered under this coverage. For a limited number of services and supplies, We may not have arrangements with Participating Providers.

Nonparticipating Providers

Providers who have not signed a PPO Provider contract with Us are Non-Participating Providers under this Point-of-Service plan. When you visit a Non-Participating Provider you may have higher out-of-pocket expenses. Your Out-of-Network Cost Sharing responsibilities for Non-Participating Providers may be found on the *Health Benefit Plan Description Form* under the “Out-of-Network” heading.

- We pay the benefits of this BlueAdvantage Point-of-Service Rider directly to Non-Participating Providers, when you have authorized assignment of benefits. We require a copy of the assignment of benefits for Our records. These payments fulfill our obligation to you for those services.

Choosing a Provider

Your Provider choice, Participating or Nonparticipating can make a difference in the amount you pay. Therefore, before choosing a Provider for health care services, you may want to check your Provider directory.

If you do not have a current directory, contact customer service or your group administrator for a complete list of Participating Providers.

Although a directory is current as of the date published, it is subject to change without notice. To verify a Provider’s current status with Us, or if you have any questions about how to use a directory, contact a customer service representative.

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

The contracts between Us and our Providers include a “hold harmless” clause which provides that you cannot be responsible to the Provider for claims owed by Us for health care services covered under this BlueAdvantage Point-of-Service Rider.

Maximum Allowed Amount

This section describes how We determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by Participating and Non-Participating Providers is based on your plan's Maximum Allowed Amount for the Covered Service that you receive.

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

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

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

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

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

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

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

Providers who have not entered into a PPO Provider contract with Us are Non-Participating Providers.

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

1. An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with Us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
4. An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

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

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

Cost-Sharing Requirements

This rider requires that you share the cost of certain health care expenses. This section describes the different Cost Sharing requirements. In-Network and Out-of-Network Cost Sharing requirements are separate and do not contribute toward one another.

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

Your cost share amount and out-of-pocket limits may vary depending on whether you receive services from a Participating or Non-Participating Provider. Specifically, you may be required to pay higher cost sharing amounts when using Non-Participating Providers. Please see the *Health Benefit Plan Description Form* under the heading "Out-of-Network" for your cost share responsibilities and limitations, or call customer services to learn how your health benefit coverage 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 the Provider for non-Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Both services specifically excluded by the terms of this BlueAdvantage Point-of-Service Rider and those received after benefits have been exhausted are non-Covered Services. Benefits may be exhausted by exceeding, for example, the lifetime maximum, benefit caps or day/visit limits.

Deductible

You must pay a Deductible (unless otherwise specified) each Benefit Period before payment for Covered Services begins under this rider. Your *Health Benefit Plan Description Form* indicates the amount of your Deductible. The Deductible requirements must be met before you begin paying Coinsurance for benefits under this rider.

Individual Deductible — Each Member's Benefit Period Deductible is specified in your *Health Benefit Plan Description Form*.

Family Deductible — All covered family Members meet the Deductible when the combined Deductible amounts for two or more family Members reach the amount specified in your *Health Benefit Plan Description Form*.

Once a family member has met his/her own individual Deductible limit, that person cannot contribute any more toward the family Deductible. Only that one person is eligible for benefits until one or more additional family members meet the other half of the family Deductible.

Carryover Deductible Credit — At the beginning of each Benefit Period, We will review the amounts applied to your Out-of-Network Deductible during the last three months of the previous Benefit Period. Any amounts applied for services received during the last three months of the previous Benefit Period will be carried over and applied to your Deductible requirement for the new Benefit Period.

Coinsurance

Under this rider, you are responsible for paying a percentage for Covered Services, called “Coinsurance,” after the Benefit Period Deductible is met. Please refer to your *Health Benefit Plan Description Form* for Coinsurance information.

Out-of-Pocket Annual Maximum

This rider also includes a separate Out-of-Network Out-of-Pocket Annual Maximum designed to protect you from catastrophic health care expenses. After the Out-of-Network Out-of-Pocket Annual Maximum is reached, payment will be made which will satisfy the remaining payment obligations up to the Maximum Allowed Amount for the remainder of that Benefit Period.

The Out-of-Pocket Annual Maximum limit under this rider includes only the Out-of-Network Coinsurance. It does not include copayments penalty amounts, Deductible amounts, expenses in excess of the Maximum Allowed Amount, or expenses for noncovered services.

Individual Out-of-Pocket Limit — Each Members Benefit Period Out-of-Pocket Annual Maximum is specified in your *Health Benefit Plan Description Form*.

Family Out-of-Pocket Limit — All covered family members meet the Out-of-Pocket Annual Maximum when combined Out-of-Pocket Annual Maximum amounts for two or more family Members reach the amount specified in your *Health Benefit Plan Description Form*.

If any one family member’s Out-of-Pocket Annual Maximum reaches the individual limit, that person cannot contribute any more toward the family Out-of-Pocket Annual Maximum. Only that one person is eligible for benefits until one or more additional family members meet the other half of the family Out-of-Pocket Annual Maximum.

Preauthorization

You or your Provider must obtain Preauthorization before certain services are received, or payment for Covered Services will be reduced or denied as explained below. Refer to the **Managed Care Features** in the **ABOUT YOUR HEALTH COVERAGE** section of your HMO Certificate under the section, for information on Preauthorization requirements.

For Covered Services from Out-of-Network Providers if your Provider is Participating, the Provider is responsible for obtaining Preauthorization. If your Provider is Nonparticipating, you are responsible for ensuring that your Provider has obtained Preauthorization, or payment will be reduced or denied as explained under **Penalty for Not Obtaining Preauthorization** below.

Your Provider must call the number for Preauthorization on your Health Benefit ID Card to request Preauthorization. We will review the request for Preauthorization.

Penalty for Not Obtaining Preauthorization

If authorization for a Covered Service from a Nonparticipating Provider is not obtained in advance payment may be reduced:

- If there has been no Preauthorization for services that would have been preauthorized if a request had been received, a penalty of 20 percent based on the Maximum Allowed Amount will be applied. This penalty amount is in addition to all Deductible and Coinsurance requirements. If your Out-of-Pocket Annual Maximum is reached, you are still responsible for the penalty amount.
- If Preauthorization is denied or if the services would not have been authorized if a request had been received, all related claims will be denied.

Any penalty amounts you pay do not contribute to your Out-of-Pocket Annual Maximum.

Point-of-Service Rider Covered Services

Out-of-Network Benefits

You may receive Out-of-Network benefits for Covered Services that are not provided by an In-Network Provider or that are provided without Our Authorization. Out-of-Network benefits are available under this rider for all Covered Services under the BlueAdvantage HMO Certificate, except as specified in the **POINT-OF-SERVICE RIDER GENERAL EXCLUSIONS** section of this rider. All services are also subject to the **GENERAL EXCLUSIONS** section of your BlueAdvantage HMO Certificate.

Covered Services for Emergency Care, Urgent Care and Emergency Ambulance Services are covered as In-Network benefits even if received from an Out-of-Network Provider.

Out-of-Network benefits are subject to Deductible and Coinsurance, and the Preauthorization procedures described in **HOW THE POINT-OF-SERVICE RIDER WORKS** section. Some Covered Services are limited to a certain number of visits or a certain maximum payment limit. For specific Deductible and Coinsurance amounts, and benefit limitations, see your *Health Benefit Plan Description Form*.

Combined BlueAdvantage HMO In-Network and Point-of-Service Out-of-Network Limitations

Certain Covered Services have a limited number of days or visits and/or Benefit Period Maximums as described in your *Health Benefit Plan Description Form*.

For example, if you receive a Covered Service that has a 10-visit maximum, you may visit an In-Network Provider six times for the services and an Out-of-Network Provider for the remaining four visits. When the Deductible is applied to a Covered Service which has a maximum number of days or visits, the maximum benefits may be reduced by the amount applied to the Deductible, whether or not the Covered Service is paid by Us. These maximums apply even if you have satisfied the applicable Out-of-Pocket Annual Maximum. You may use any such combination of In-Network and Out-of-Network benefits up to the limits as specified in the *Health Benefit Plan Description Form*.

Point-of-Service Rider General Exclusions

In addition to the **GENERAL EXCLUSIONS** in your BlueAdvantage HMO Certificate, the following exclusions also apply. However, the following Point of Service rider exclusions may be covered under your BlueAdvantage HMO Certificate.

- Non-Emergency Ambulance and Transportation Services.
- Infertility Services.
- Human Organ and Tissue Transplant Services.
- Outpatient Prescription Drugs.
- Services requiring Preauthorization - certain services require Preauthorization in advance. If you choose to receive the services without obtaining Preauthorization for Nonparticipating Providers, payment may be reduced. See **Preauthorization** in the **HOW THE POINT-OF-SERVICE RIDER WORKS** section for a list of services requiring prior authorization and details on how to obtain authorization and for information on the penalty amounts for not obtaining prior authorization.

Point-of-Service Rider General Provisions

All provisions of your BlueAdvantage HMO Certificate are used to determine whether services are covered under this rider, unless specifically addressed in this rider.

How and Where to Send Claims

If you go to a Participating Provider, the Provider will file your claims.

We or our designee administers claims under this rider. Submit claims to the address specified on your Health Benefit ID Card in accordance with the provisions of the Claims Payment and Appeals section in your BlueAdvantage HMO Certificate. We pay the benefits of this BlueAdvantage Point-of-Service Rider directly to Non-Participating Providers, when you have authorized assignment of benefits. We require a copy of the assignment of benefits for Our records. If We pay you directly, you are responsible for paying the Provider of services for all charges. These payments fulfill our obligation to you for those services.

How Payments Are Made

After a claim has been processed, you will receive an explanation of benefits (EOB). When the Member is a dependent child of divorced parents, the custodial parent may receive the EOB. Payments for Covered Services are sent directly to Participating Providers and you receive an EOB that explains the payment. If payment for Covered Services is sent to you, the check is attached to the EOB. The EOB indicates what services were covered and what services, if any were not.

Our payments to Providers are based upon Provider agreements and the Maximum Allowed Amount as determined by Us. You are responsible for paying all Deductible amounts, Coinsurance, penalty amounts, and expenses for non-covered services. Payments for Covered Services received from a Nonparticipating Provider are made to you. You are responsible for paying the Nonparticipating Provider, including any amounts greater than Our Maximum Allowed Amount.

Point-of-Service Rider Glossary

This section defines certain words used in this rider that are either not defined in the Glossary of your BlueAdvantage HMO Certificate or are used in a different way in your BlueAdvantage HMO Certificate. Please see the Glossary of your BlueAdvantage HMO Certificate for additional definitions.

Anthem Blue Cross and Blue Shield — Means Rocky Mountain Hospital and Medical Service, Inc., doing business as Anthem Blue Cross and Blue Shield (also referred to as Anthem).

Billed Charge — the amount billed by the Provider for the service or supply. The Billed Charge may be different from the Maximum Allowed Amount. If the Provider is Nonparticipating, you are responsible for the Billed Charge, regardless of the Maximum Allowed Amount or the amount of the benefit payment.

Coinsurance — An arrangement under which you share costs with Us after the Deductible is met. The amount of Coinsurance you pay to a Provider is calculated after the determination of the Maximum Allowed Amount, after We subtract any discount(s) We may have negotiated with the Participating Provider.

Deductible — an amount that is required to be paid by you before We will begin to reimburse for Covered Services. Some Covered Services have a maximum benefit of days, visits, or dollar amounts allowed in a Benefit Period. When the Deductible is applied to a Covered Service which has a maximum benefit, the maximum benefit will be reduced by the amount applied toward the Deductible, whether or not the service is paid by Us.

Maximum Allowed Amount - The maximum amount that We will allow for Covered Services that you receive. More information can be found in the **HOW THE POINT-OF-SERVICE RIDER WORKS** section under **Choosing a Provider**.

Non-Participating Provider — a Provider defined as one of the following:

- A Facility Provider, such as a Hospital, that has not entered into a PPO Provider contract with Us;
- A Professional Provider, such as a Physician, who has not entered in to a PPO Provider contract with Us;
- Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this BlueAdvantage Point-of-Service Rider.

Out-of-Network — a term for PPO or Non-Participating Provider or Facility that has not enter into a network agreement with HMO Colorado. Services received from a PPO or Non-Participating Provider, usually result in a higher out-of-pocket expense to you than services rendered by a HMO Colorado In-Network Provider.

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

Participating Provider — a Provider who is in the provider network for this specific health benefits program.

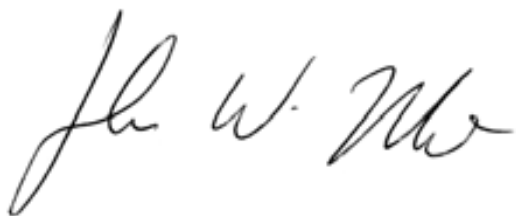
Welcome

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

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

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

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

A handwritten signature in black ink, appearing to read "John W. Martie". The signature is fluid and cursive, with the first letters of each name being capitalized and prominent.

John Martie
President and General Manager
HMO Colorado

Anthem Blue Cross and Blue Shield is the parent company of HMO Colorado, Inc. An independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks Blue Cross and Blue Shield Association

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

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

Health benefit coverage is defined in the following documents:

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

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

- The Employer Master Application
- The Employer Master Contract between Us and the employer

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

This Certificate is not a Medicare Supplement policy. If you are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Anthem Blue Cross and Blue Shield. Contact our customer service department for information on how to obtain this guide.

Care Outside of Colorado

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

The Away From Home CareSM benefit is designed to bring you peace of mind if you are on vacation, have a dependent attending school in another state or have family members living in a different service area.

Short Trips

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

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

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

Extended Stays

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

- Call Guest Membership toll free at 1-800-827-5422 for eligibility and specific location information. Guest Membership is not available in all areas.
- If a participating HMO (Host HMO) is in your destination area, Guest Membership will send you an application to complete, sign and return in an enclosed self-addressed envelope. Guest Membership will forward your completed application to the Host HMO. Please allow 20-30 calendar days for processing your application.
- The Host HMO will send you a health plan identification card, the name of your Primary Care Physician (in some cases, you may be asked to choose a Primary Care Physician), and information on how to use your Guest Membership.
- The Host HMO does not cover dental, vision, chiropractic care and substance abuse rehabilitation.
- Use your HMO Colorado health plan identification card to access prescription benefits in the Host HMO area.

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

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

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YOUR RIGHTS AND RESPONSIBILITIES

We are committed to:

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

You have the right to:

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

You have the responsibility to:

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

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

ABOUT YOUR HEALTH COVERAGE

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

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

Primary Care Physicians

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

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

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

Selecting A PCP

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

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

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

Visiting A PCP

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

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

After hours care is provided by your physician who may have a variety of ways of addressing your needs. You should call your PCP for instructions on how to receive medical care after the PCP's normal business hours, on weekends and

holidays, or to receive non-Emergency Care and non-Urgent Care within the service area for a condition that is not life threatening but that requires prompt medical attention. In case of an Emergency, you should call 911 or go directly to the nearest Emergency room. If you are outside the service area, non-emergency Covered Service may be covered under the BlueCard Program. More information about the BlueCard® program can be found on the page entitled Care Outside of Colorado located in the front of this Certificate.

Changing PCPs

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

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

If you change primary residence or place of employment to a location that is not convenient to your current PCP's office, you may choose a new PCP nearer to your new residence or place of employment, within Our Service Area. You must notify Us within 31 days after a change in residence or place of employment by submitting an Enrollment Application and Change Form.

Care Outside of Colorado

When you are outside Our service area for extended periods of time, care is available through the BlueCard® Program or through the Guest Membership benefit. Details on the away from home care programs can be found in the front of this Certificate under the heading entitled Care Outside of Colorado.

Cost Sharing Requirements

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

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

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

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

Copayment

Copayments are your Cost Sharing requirements under this coverage. A Copayment is a predetermined, fixed-dollar amount you must pay to receive a specific Covered Service. You are required to pay a Copayment to In-Network Providers for specific Covered Services as listed in the *Health Benefit Plan Description Form*. You are responsible for making Copayments directly to the In-Network Provider.

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

Out-of-Pocket Annual Maximum

The Out-of-Pocket Annual Maximum is designed to protect you from catastrophic health care expenses. Once you and/or your family have satisfied the Out-of-Pocket Annual Maximum for Inpatient Hospital Facility services, Outpatient Hospital/Alternative Care Facility services (except MRI, CT, PET scans, therapy services, rehabilitation services and Emergency Care), no additional Copayments shall be required from you and/or your family for the remainder of the Benefit Period for those services listed on the *Health Benefit Plan Description Form*. The Out of Pocket Annual Maximum is found on the *Health Benefit Plan Description Form*.

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

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

Benefit Period Maximum

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

Managed Care Features

Managed Care is a system of health care delivery with the goal of giving you access to quality, cost effective health care while optimizing utilization and cost of services, and measuring In-Network Provider and coverage performance. We use a variety of administrative processes and tools, such as Preauthorization for health care services, Care Management, concurrent Hospital review and Disease Management to help determine the most appropriate use of the health care services available to Our Members. This section of the Certificate explains how these Managed Care features are used and will guide you through the necessary steps to obtain care. For more information about how you should proceed in case of Emergency care and Urgent care, please see the **COVERED SERVICES** section.

Transition of Care

A new Member to this coverage may be receiving ongoing care for a medical condition. Examples of ongoing care include prenatal/obstetrical care, Home Care or Hospice Care. We strive to avoid disruption of a new Member's care through Our transition of care policy. To facilitate the transition of care, you or your provider must review the reference sheet, complete a Transition of Care Form and submit them to Us for review. You or your Provider may request a reference sheet and Transition of Care Form by calling Our medical management department at 303-831-3238 or 1-800-797-7758.

Our Process to Determine If Services are Covered

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

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

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

Experimental/Investigational and/or Cosmetic Procedures - We will not pay for any services, procedures, surgeries or supplies that We consider Experimental/Investigational and/or cosmetic. Additionally We will not pay for complications arising from any services, procedures, surgeries or supplies that we consider Experimental/Investigational and/or cosmetic.

Appropriate Place and Preauthorization

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

Preauthorization is a process We use to determine if a requested service or supply is a covered benefit and that your care is provided in the most medically appropriate setting. The Preauthorization process may set limits on the coverage available under this Certificate. Preauthorization is required before a Hospital admission or before receiving certain procedures or services. Some drugs also require Preauthorization.

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

Inpatient Admissions - Admissions for all inpatient stays require Preauthorization and concurrent reviews. Your In-Network Provider must call the number for **Provider Authorization** on your Health Benefit ID Card to request Preauthorization. We will review the request for Preauthorization. If the inpatient stay is approved, all benefits available under your coverage are provided. We initially authorize a specified number of days for the inpatient stay and reevaluate such Authorization if additional days are requested by the In-Network Provider. This process facilitates your timely discharge or transfer to the appropriate level of care.

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

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

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

Inpatient admissions include admissions to Acute Care facilities (Hospitals), Long-Term Care Facilities, sub-acute facilities, rehabilitation facilities, Skilled Nursing Care facilities and inpatient Hospice Facilities.

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

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

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

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

You or your representative may appeal our Preauthorization decision by following the procedure outlined in the **COMPLAINTS, APPEALS AND GRIEVANCES** section.

Appropriate Length of Stay

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

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

At some point during hospitalization, We may determine that further hospitalization is not Medically Necessary. We will advise your attending Physician and the Hospital of this determination. You may elect to remain in the Hospital after you have been notified that continued hospitalization is not Medically Necessary, but We will not pay for services after the recommended date of discharge. We will also send written notification of the decision to you, the attending Physician and the Hospital. **You will be responsible for all charges incurred after the recommended day of discharge.**

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

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

Ongoing Care Needs

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

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

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

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

Our Care Management program is tailored to the individual. In certain extraordinary circumstances involving intensive Care Management, We may, at our sole discretion, provide benefits for alternate care that is not listed as a Covered

Service in this Certificate. We may also extend Covered Services beyond the contractual benefit limits of this coverage. We will make these decisions on a case-by-case basis. A decision in one case to provide extended benefits or approve care not listed as a Covered Service in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or cease providing extended benefits or approving care not listed as a Covered Service. In such cases, We will notify you or your representative in writing.

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

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

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

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

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

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

MEMBERSHIP

Subscriber

The Subscriber is a Member in whose name the membership is established.

A new employee who has a regular work week as specified in the Employer Master Contract is eligible to enroll for coverage as a Subscriber. The employee must contact the employer for the minimum number of hours that must be worked per week and other requirements to qualify for coverage.

Dependents

A Subscriber's Dependents may include the following:

- **Legal Spouse.**
- **Common-law Spouse.** The Subscriber must submit a Common-Law Marriage Affidavit for the common-law Spouse to be considered for enrollment. The Common-Law Marriage Affidavit may be obtained through the employer or by calling Our customer service department. All references to spouse in this Certificate include a Common-Law spouse.
- **Domestic Partner.** A domestic partner of the same or opposite gender that meets the criteria as established by the employer. Completion of an Affidavit of Domestic Partnership is required. A domestic partner is not a legal spouse under Colorado law. Coverage also includes natural or adopted children of a domestic partner if the dependent child satisfies the criteria of a dependent as indicated below.
- **Newborn child.** A newborn child born to the Subscriber or Subscriber's Spouse is covered under the Subscriber's coverage for the first 31 days after birth. If the mother of the newborn child is a Dependent child of the Subscriber, the newborn is **not** covered (see the **Grandchild** heading in this section).

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

To continue the newborn child's participation in the coverage beyond the 31-day period after the newborn child's birth, the Subscriber who has a non-family policy must complete and submit an Enrollment Application and Change Form to add the newborn child as a Dependent child to the Subscriber's policy. We must receive the Enrollment Application and Change Form within 31 days after the birth of the child to continue coverage for the 32nd day and thereafter. Subscribers do **not** need to complete an Enrollment Application and Change Form to add the newborn child as long as they had family coverage that requires no additional premium at the time of birth of the newborn child and they provide Anthem notice within 60 days of the child's birth.

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

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

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

- **Dependent child.** A child (including a stepchild or a disabled child) under 26 years of age may be covered under the terms of this Certificate. At the end of the birth month in which the child turns age 26 the Dependent child is removed from coverage. If the Subscriber or the Subscriber's Spouse is subject to a qualified medical child support order for a Dependent child of the Subscriber or the Subscriber's Spouse, the Dependent child is eligible for coverage, whether the child lives with the Subscriber or the Subscriber's Spouse. The dependents (spouse or child) of a Dependent child are not eligible for coverage under this certificate.
- **Disabled Dependent child.** An unmarried child who is 26 years of age or older, medically certified as disabled, and Dependent on the parent may be covered under the terms of this Certificate. We must receive notice of the disability for the disabled Dependent coverage to continue after the Dependent child turns age 26. The Subscriber and the disabled Dependent's Physician must complete and submit a Mentally or Physically Disabled Dependent Form to Us.

You may call Our customer service department or go to Our website to obtain a Mentally or Physically Disabled Dependent Form.

- **Grandchild.** A grandchild of a Subscriber or a Subscriber's Spouse is not eligible for coverage unless the Subscriber or the Subscriber's Spouse is the grandchild's court-appointed permanent guardian or has adopted the grandchild. The Subscriber must submit an Enrollment Application and Change Form and evidence of court appointment as permanent guardian or documents evidencing a legal adoption. Another option is to enroll the grandchild under an Individual Membership with Anthem Blue Cross and Blue Shield, subject to its terms and conditions.

Medicare-Eligible Members

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

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

Enrollment Process

For eligible Subscribers and their eligible Dependents to obtain coverage, the Subscriber must follow Our enrollment process, which details who is eligible and what forms are required for enrollment. Coverage under this Certificate begins as of the Effective Date as indicated in Our files. No services received before that date are covered.

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

Note: You have the right to obtain a Certificate of Creditable Coverage from your prior plan. Please contact customer service department for assistance in obtaining such certificate or if you have any questions regarding Pre-Existing Conditions.

Enrollment Forms

The Subscriber must submit an Enrollment Application and Change Form to add any Dependents as Members. Additional forms may be required for special Dependent status. Subscribers may obtain an Enrollment Application and Change Form or any additional forms from their employer, Our customer service department or Our website at www.anthem.com.

Initial Enrollment

Eligible employees may apply for coverage for themselves and their eligible Dependents by submitting an Enrollment Application and Change Form. We must receive the Enrollment Application and Change Form within 31 days after the date of hire or within 31 days of the expiration of the waiting period, as defined in the employer's new hire policy. The Effective Date of coverage will be determined in accordance with any established waiting period as defined in the Employer Master Contract. The employer will inform the employee of the length of the waiting period.

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

Open Enrollment

Any eligible employee who has satisfied the waiting period as defined by the employer and did not enroll when initially eligible, as a newly eligible dependent or during a special enrollment may enroll during the employer's annual Open Enrollment period, which is generally a 31-day period before the employer's Anniversary Date. The employer's benefit coordinator will provide the Open Enrollment period date and the Anniversary Date to the eligible employee.

Newly Eligible Dependent Enrollment

A current Subscriber of this coverage may add a Dependent who becomes newly eligible due to a qualifying event. Qualifying events include marriage, birth, placement for adoption or issuance of a court order. We must receive an Enrollment Application and Change Form for the addition of the Dependent within 31 days after the date of the qualifying event. Proof of the qualifying event, e.g., a copy of the marriage certificate or court order, must be attached to the completed Enrollment Application and Change Form. Coverage will be effective on the date of the qualifying event.

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

Special Enrollment for Eligible Employees and Eligible Dependents

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

Family Status Change - Qualifying events for special enrollment due to a family status change include marriage, divorce, birth, placement for adoption or the issuance of a qualified medical child support order. Coverage with Us will be effective on the date of the qualifying event. When the qualifying event is a birth, and the mother is not previously enrolled, any charges related to labor and delivery due to the birth are not covered. We must receive the completed Enrollment Application and Change Form within 31 days after the date of the qualifying event. Proof of the qualifying event, e.g., a copy of the marriage certificate or court order, must be attached to the completed Enrollment Application and Change Form.

Involuntary Loss of Coverage – For the eligible employee and/or eligible Dependent to qualify for special enrollment due to involuntary loss of the other group health insurance coverage, the loss of coverage must be due to termination of employment, reduction in the number of hours of employment, involuntary termination of Creditable Coverage, death of an employee, legal separation or divorce, cessation of dependent status, the other plan no longer offering any benefits to the class of individuals, or the termination of employer contributions toward the coverage. If the other coverage does not provide benefits to individuals who no longer reside, live or work in a service area, and no other benefit package is available, loss of coverage because an individual (voluntarily or involuntarily) no longer resides, works or lives in the service area will be considered an involuntary loss of coverage. If the employee is approved for special enrollment, the coverage with Us will be effective on the day following the loss of other coverage. If COBRA or state continuation coverage is available, enrollment may only be requested after exhausting the COBRA or state continuation coverage.

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

Status Change of State Medicaid Plan or State Child Health Insurance Program (SCHIP) - Loss of eligibility from a state Medicaid or SCHIP health plan is also a qualifying event for special enrollment for the eligible employee and/or eligible Dependents. The employee must properly file an application with the employer within 60 days after coverage has ended, Medicaid coverage has ended, or 90 days after SCHIP coverage has ended. In addition, special enrollment is allowed for the employee who becomes eligible for premium assistance, with respect to coverage under the employer's health coverage, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. Similarly, the employee must properly file an application with the employer within 60 days after the eligibility date for assistance is determined.

Military Service

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

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

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However,

an exclusion or waiting period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

Multiple Coverages by Us

You may have more than one group health insurance policy with Us or any of Our affiliates. To be eligible for a Premium refund, you must notify us within 31 days after the date on which duplicate coverage begins if that duplicate coverage is not desired. If we do not receive notification within this 31-day period, no retroactive refund of Premium payments will be granted; however, you may still be able to terminate the duplicate coverage.

How to Change Coverage

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

Termination

Active Policy Termination

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

- On the date the Employer Master Contract between the employer and Us is terminated.
- Upon the Subscriber's death.
- When the required Premium has not been paid.
- When you or your employer commits fraud or intentional misrepresentation of material fact.
- When you are no longer eligible for coverage under the terms of the Employer Master Contract.
- When you are deemed a "working aged," as defined by federal law, and Medicare becomes your primary coverage unless you are in a group with fewer than 20 employees.
- When the Subscriber's employer gives Us written notice that the Subscriber is no longer eligible for coverage. Coverage will be terminated on the date of notification or at the end of the month of the qualifying event. We reserve the right to recoup any benefit payments made for dates of service after the termination date.
- When We receive a 31-day advance written notification to cancel coverage for any Member, coverage will end at the end of the month following the 31-day advance written notification period or at the end of the month of the qualifying event. We will credit membership Premium paid in advance on behalf of canceled Members unless We do not receive the cancellation request at least 31 days before the Effective Date of the cancellation.
- When you move and therefore neither reside nor work within the service area unless you are continuing coverage under COBRA continuation, you must notify Us within 31 days of such a change in location. Coverage will end on the last day of the month in which the change of residence is reported; until that time, the only out-of-area services covered will be Emergency care and Urgent care. Non-Emergency care will not be covered.
- If you do not notify Us of a change of residence or workplace to an area outside Our Service Area, and We later become aware of the change, your coverage may be retroactively terminated to the date of the change of residence or place of employment. You will be liable to Us and/or the Providers for payment for any services covered in error.
- When We cease operations.

Dependent Coverage Termination

To remove a Dependent from coverage, the Subscriber must complete an Enrollment Application/Change Form 31 days before the Effective Date of the change. If we receive the change notification after the requested Effective Date, the change will be effective on the date We are notified of the change. We reserve the right to recoup any benefit payments made after the termination date.

We will credit membership Premium paid in advance on behalf of the terminated Dependent unless We do not receive the Enrollment Application and Change Form within 31 days before the Effective Date of the change or if We have paid any claims on behalf of the terminated Dependent in the period for which the credit would otherwise be owed to the employer.

Coverage for a Dependent ends on the last day of the month immediately preceding the next monthly Premium due date following receipt of the request or on the first occurrence of one of the following events:

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

Certificate of Creditable Coverage

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

What We Will Pay for After Termination

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

When your coverage is terminated for any reason other than for nonpayment of Premium, fraud or abuse, We shall provide for your continued care if you are being treated at an inpatient facility, until you are discharged or transferred to another level of care, subject to the terms of this Certificate. The discharge date is considered the first date on which you are discharged from the facility or transferred to another level of care. When coverage has been terminated and you receive additional facility care after the discharge date, We will not cover additional services received.

Continuation of Coverage

Family and Medical Leave Act

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

COBRA Eligibility and Notification

COBRA Eligibility - For employers with 20 or more employees, Subscribers and their Dependents who lose eligibility with a group may be eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). You should contact the employer for additional information. COBRA coverage is available for 18, 29 or 36 months, depending on the qualifying event(s), and only if the application and Premium payment requirements of the federal law are met.

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

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

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

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

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

- The surviving Spouse and surviving children of a covered employee, when the covered employee dies.
- The covered employee, if the employee became eligible for Medicare benefits before COBRA election.

- Spouse and Dependent children of covered employee, if the employee became eligible for Medicare benefits before COBRA election.
- Spouses and Dependent children of a covered employee, when the employee and the Spouse separate or divorce.
- Dependent children of the covered employee, when the Dependent children lose eligibility as Dependents.

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

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

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

Termination of COBRA

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

Continuation coverage may terminate before the continuation period expires if:

- The Employer Master Contract between the employer and Us is terminated. If the employer selects a replacement group coverage, continuation coverage will continue under the new coverage.
- You fail to pay Premium in a timely manner.
- Under COBRA coverage, you are covered by another group health insurance policy unless the other coverage excludes a condition covered by the COBRA coverage; in that case, the COBRA coverage continues until exhausted or the other coverage covers the excluded condition.
- The date the spouse remarries and becomes eligible for coverage under the new spouse's policy of group health insurance.
- Under COBRA coverage, you become covered by Medicare.
- Your COBRA coverage was extended to 29 months and you are determined under the Social Security Act to no longer be disabled.
- You submit written notice of voluntary cancellation of coverage.

Conversion

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

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

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

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

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

For groups of 50 or fewer employees, conversion coverage is available to all employees of the group if the group health care coverage is terminated by either Us or the employer for reasons other than replacement with other group health care coverage or fraud and abuse in obtaining and utilizing coverage. Conversion coverage privilege is available even if the group coverage is terminated because the group did not pay Premiums. The conversion coverage will be group coverage under Our Basic or Standard Plans. The employer must notify each employee of the right to conversion coverage. When the group coverage as a whole is not being terminated; but rather, an individual employee or Dependent's group coverage eligibility is being terminated, conversion coverage may be available, subject to the terms as described above.

COVERED SERVICES

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

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

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

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

Preventive Care Services

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

Preventive Care Services means care that is rendered to prevent future health problems for a Member who does not exhibit any current symptoms. Coverage for benefits in this section shall meet or exceed those required by law. Coverage may vary based on your age, sex and/or personal history. Preventive care services are developed from national guidelines recommended by such agencies as the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family Physicians. Consult with your Physician for specific health guidelines. See your *Health Benefit Plan Description Form* for any limitations. Preventive Care Services include:

Routine Exams and Immunizations

- Routine or periodic exams, e.g., pelvic exams. Exams are covered according to the frequency determined by your Provider. Having the right exams at the right times may help you avoid serious illness;
- Family history, current health problems and lifestyle all affect your risk for disease. Talk to your Provider to determine if you are at high risk for specific diseases and then together determine your appropriate exam schedule;
- Immunizations (including those required for school) and immunizations against cervical cancer to the extent required coverage is by applicable insurance law. Immunizations protect you from certain diseases and help prevent epidemics. While immunization risks to your health are low, the risks from disease are high. Both children and adults need immunizations to help keep them healthy;
- Child Health Supervision Services (including limited smoking cessation services) for Dependent children up to age 13, but only to the extent coverage is required by applicable insurance law.
- Annual medical diabetes eye exams, or in accordance with the frequency determined by your Provider.
- Flu shot in your when received from your Provider's office. If it's more convenient to get your flu shot at a flu shot clinic, you may be eligible for reimbursement of some or all of your out of pocket costs. Reimbursement for one flu shot per Benefit Period, or as determined by Us, at locations such as a flu shot clinic location. Examples of locations that may provide flu shots and may be considered flu shot clinics include your local pharmacy, your place of employment, a grocery store, Wal-Mart, Walgreens or Costco. There may be additional flu shot clinic locations available to you. Information on the reimbursable flu shot benefit, including the claim form and reimbursement amount, are located on our website at anthem.com. The claim form you need to submit for reimbursement and the reimbursement amount is available on Our website at www.anthem.com or call our customer service department. This annual reimbursement is subject to change. Your cost for a flu shot received from an Out-of-Network Provider as defined in this Certificate, or flu shots otherwise paid for in full or in part by another party, are not eligible for reimbursement.

- Pneumococcal vaccinations.

Routine/Preventive Diagnostic Services

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

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

Infertility Services

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

Benefits include Inpatient Services, Outpatient Services, and Physician Office Services for the diagnosis of infertility. Covered Services include only diagnostic and exploratory procedures to determine the cause of infertility. See the *Health Benefit Plan Description Form* for benefit limitations and the lifetime benefit. If you change between two or more of Our products within the same benefit design, the same lifetime maximum benefit applies. If however, you change from coverage under one benefit design to coverage under a different benefit design, a separate and new lifetime maximum benefit begins with the new coverage.

Maternity Services and Newborn Care

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

Maternity Services include Inpatient Services, Outpatient Services and Physician Office Services for normal pregnancy, one routine Ultrasound, cesarean section, complications of pregnancy, spontaneous termination of pregnancy prior to full term, therapeutic abortion, and ordinary routine nursery care for a well newborn, in addition to all Medically Necessary care and treatment of injury and sickness, including medically diagnosed Congenital Defects and Birth Abnormalities for covered newborns.

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

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

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

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

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

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

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

- You have a medical condition as determined by the Physician, which represents a serious threat to your life if the pregnancy is allowed to continue; or
- There is a medical condition in the unborn child, as confirmed by two Physicians, which would result in the death of the unborn child during the term of the pregnancy or at birth; or
- There is a psychiatric condition, which represents a serious and substantial threat to your life if the pregnancy continues. The Physician must obtain consultation from a licensed Physician specializing in psychiatry confirming the presence of such a psychiatric condition unless you have been receiving prolonged psychiatric care.

Diabetes Management Services

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

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

- Ordered in writing by a Physician; and
- Provided by a Health Care Professional who is certified, registered or licensed with expertise in diabetes.

A diabetes education session must be provided by a Health Care Professional in an Outpatient facility or in a Physician's office.

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

Physician Office Services

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

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

Covered Physician office services include visits for medical care, consultations and second opinions to: examine, diagnose and treat an illness or injury performed in the Physician's office, including birth control. Office visits also include allergy injections and allergy serum, allergy testing and non-urgent or non-emergency care. Office visits may include administration of injections. If a covered injection requires the use of one of the Specialty Pharmacy Drugs listed on Our Medical Provider Administered Specialty Drug List that Specialty Pharmacy Drug must be received from Our Specialty Pharmacy to be covered. Self-injectable Specialty Drugs administered by a healthcare professional, but are not required to be administered by a healthcare professional in the office setting, must be billed by the Provider through the pharmacy benefit. See the **SPECIALTY PHARMACY** section for more information.

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

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

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

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

Inpatient Services

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

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

Inpatient Services include:

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

Skilled Nursing Care Facility (SNF)

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

Inpatient Rehabilitation Therapy

Inpatient medical rehabilitation therapy benefits for medically necessary care for the primary purpose of restoring and/or improving lost functions following an injury or illness, limited to a maximum number of days per the member's benefit year as listed on the *Health Benefit Plan Description Form*. Inpatient rehabilitation therapy may be received at an Acute Rehabilitation Facility, Skilled Nursing Facility, Long term Acute Care Facility or a Sub-acute Facility. In the Certificate We refer to three types of inpatient rehabilitation therapy: Acute Rehabilitation Therapy, Chronic Rehabilitation Therapy and Sub-Acute Rehabilitation Therapy.

Room, Board and General Nursing Services

- A room with two or more beds;
- A private room, however the allowance is the Provider's average semi-private room rate unless it is Medically Necessary that you occupy a private room for isolation and no isolation facilities are available; and
- A room in a Special Care Unit approved by Us. The Special Care Unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary Services

- Operating, delivery and treatment rooms and equipment;
- Prescribed drugs administered as part of the Inpatient admission;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services;
- Therapy Services; and

- Charges for processing, transportation, handling and administration of blood. Charges for blood, blood plasma and blood products unless received from a community source.

Professional Services

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

Copayment Waiver

When a Member is transferred from one Hospital or other Facility Provider to another Hospital or other Facility Provider on the same day, any Copayment stated per admission in the *Health Benefit Plan Description Form* is waived for the second admission. Copayments stated as a percentage or per day are not waived.

Outpatient Services

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

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

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

Outpatient Services may include administration of injections. If a covered injection requires the use of one of the Specialty Pharmacy Drugs listed on Our Medical Provider Administered Specialty Drug List that Specialty Pharmacy Drug must be received from Our Specialty Pharmacy to be covered. See the **SPECIALTY PHARMACY** section for more information.

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

For dental services refer to the **DENTAL RELATED SERVICES** section.

Diagnostic Services

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

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

- X-ray and other radiology services;
- Laboratory and pathology services;
- Cardiographic, encephalographic and radioisotope tests;
- Ultrasound services;
- Allergy tests;

- Hearing tests, unless related to an examination for prescribing or fitting of a hearing aid, except as required by applicable law;
- Genetic testing when allowed by HMO Colorado's medical policy;
- Ultrafast CT scans when Preauthorized and allowed by Anthem's medical policy.

Surgical Services

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

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

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Sterilization services;
- Anesthesia and surgical assistance as determined by our medical policy. We do not pay for all surgical assistant procedures. The list of procedures , which allow a surgical assistant or assistant surgeon, is available to your Provider;
- Usual and related pre-operative and post-operative care; and
- Other procedures as approved by Us.

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

The surgical fee includes normal post-operative care.

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

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

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

Emergency Care and Urgent Care

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

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

Emergency Care

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

We cover Emergency services necessary to screen and Stabilize you without Preauthorization if a prudent person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb-threatening emergency existed. "Life or limb-threatening Emergency" means any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Whenever you are admitted as an Inpatient directly from a Hospital emergency room the emergency room Copayment will be waived. For Inpatient admissions following Emergency Care, you should contact Us within 24 hours of admission or as

soon as reasonably possible to obtain authorization for a specific length of stay. When We are contacted for Authorization, you will be notified of the number of days considered Medically Necessary for your diagnosis.

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

Urgent Care

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

Urgent Care is care provided for individuals who require immediate medical attention but whose condition is not life-threatening (non-Emergency). Treatment of an Urgent Care medical problem is not an emergency and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and you are advised to go to an emergency room, your care will be paid at the level specified in the *Health Benefit Plan Description Form* for Urgent Care.

Obtaining Emergency or Urgent Care

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

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

Emergency and Urgent Care outside the country:

- Go to the nearest health care facility;
- Call your PCP or Us within 24 hours or as soon as reasonably possible;
- Once your care is completed, you will need to pay the bill. (You may want to use a credit card. The credit card company will automatically transfer the foreign currency into American dollars for you.) Keep all your receipts;
- When you return home, call Us at the number on the back of your Health Benefit ID Card or stop by your employer's personnel office and ask for a claim form;
- Fill out the claim form and submit it with your receipts to Our address on the form. (The amount submitted must be in American dollars); and
- You will be reimbursed based on the benefits of your Certificate.

Ambulance and Transportation Services

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

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

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

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

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

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

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

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

Copayment waiver

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

Therapy Services

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

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

Physical, Occupational and Speech Therapy

From the Member's birth until the Members sixth (6th) birthday, benefits are allowed up to the maximum visits listed on the *Health Benefit Plan Description Form*, or twenty (20) visits each, whichever is greater, per Benefit Period for physical, speech and occupational therapies. Benefits are for the care and treatment of congenital defects and birth abnormalities for covered children without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy it to maintain or improve functional capacity. The level of benefits between the third (3rd) birthday and the sixth (6th) birthday shall exceed the limit of twenty (20) visits for each therapy if such therapy is indicated in a Member's Treatment Plan for Autism Spectrum Disorders and is determined by Us to be Medically Necessary.

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

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

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

- **Speech Therapy** for the correction of a speech impairment resulting from illness, injury, surgery or as a result of a Congenital Defect or Birth Abnormality as determined by HMO Colorado's medical policy.
 - **Cleft Palate or Cleft Lip.** For a cleft palate or cleft lip condition, Speech Therapy benefits are unlimited, as long as Medical Necessity has been demonstrated. Such Speech Therapy visits reduce the maximum visits but are not limited to the maximum visits. Additional services for cleft plate or cleft lip can be found under the **DENTAL RELATED SERVICES** section.
- **Occupational Therapy** for the treatment of a person with physical disabilities or as a result of a Congenital Defect or Birth Abnormality by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. It also includes tasks required by the person's particular occupational role.
- **Osteopathic Manipulative Therapy** services to correct by manual or mechanical means structural imbalance or subluxation to remove nerve interference from or related to distortion, misalignment or subluxation of or in the vertebral column. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit.

Other Therapy Services

- **Chiropractic Therapy** services within the scope of chiropractic care that are supportive or necessary to help you achieve the physical state enjoyed before an injury or illness and are generally furnished for the diagnosis and/or treatment of a neuromusculoskeletal condition associated with an injury or illness. Coverage is provided for examinations, office visits with manual manipulation of the spine, x-ray of the spine and conjunctive physiotherapy. Benefits are allowed up to the maximum visits as listed on the *Health Benefit Plan Description Form*.
- **Massage Therapy** for injury or illness for which massage has a therapeutic effect. Coverage is provided for up to a 60 minute session per visit. Covered Services include but is not limited to acupressure, deep tissue massage, or as allowed by the massage therapists license. Benefits are allowed up to the maximum visits as listed on the *Health Benefit Plan Description Form*.
- **Acupuncture services** from an acupuncturist who acts within the scope of their license for the treatment of neuromusculoskeletal pain resulting from an injury or illness. Covered Services are allowed up to the maximum visits as listed on the *Health Benefit Plan Description Form*.
- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. Benefits are allowed at a facility for exercise and education under the direct supervision of skilled program personnel in an intensive outpatient rehabilitation program. From 6 to 36 visits are allowed based on Our Medical Policy, and the program must start within three months of the major cardiac event and be completed within six months of the major cardiac event.
- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents. Chemotherapy services are available through the Providers office. Chemotherapy medications used in conjunction with outpatient therapy may be considered Specialty Pharmacy Drugs when such medication is listed on Our Medical Provider Administered Specialty Drug List and they must be received from Our Specialty Pharmacy. See the **SPECIALTY PHARMACY** section for more information.
- **Dialysis** treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- **Radiation Therapy** for the treatment of disease by x-ray, radium or radioactive isotopes.
- **Inhalation Therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

Autism Services

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

Covered Services are provided for the assessment, diagnosis, and treatment of Autism Spectrum Disorders (ASD) for a covered dependent child. See the *Health Benefit Plan Description Form* for annual maximum benefits associated with applied behavior analysis for specific age categories. The following treatments will not be considered Experimental or Investigational and will be considered appropriate, effective, or efficient for the treatment of Autism Spectrum Disorders where We determine such services are Medically Necessary:

- a) Evaluation and assessment services;

- b) 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;
- c) Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies.
- d) Prescription Drugs, if covered under this Certificate;
- e) Psychiatric Care;
- f) Psychological Care, including family counseling; and
- g) Therapeutic Care.

Treatment for Autism Spectrum Disorders must be prescribed or ordered by a licensed physician or licensed psychologist, and services must be provided by a Provider covered under this plan and licensed to provide those services. However, behavior training, behavior management, or applied behavior analysis services (whether provided directly or as part of therapeutic care), must be provided by an Autism Services Provider. Coverage of Autism Spectrum Disorders in this section are in addition to coverage provided for early intervention and congenital defects and birth abnormalities. Autism services and the autism Treatment Plan are subject to Utilization Review.

Physical Medicine and Rehabilitation Services

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

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

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

Home Care/Home IV Therapy Services

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

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

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.);
- Medical/social services;
- Diagnostic Services;
- Nutritional guidance;
- Certified Nurse Aide services under the supervision of an R.N. or a therapist qualified with professional nursing services;
- Therapy Services (not subject to the therapy limits listed on the *Health Benefit Plan Description Form* when provided by a Home Care Agency);
- Medical and Surgical Supplies;
- Durable Medical Equipment;
- Prescription Drugs (only if provided and billed by a Home Health Care Agency); and
- Specialty Pharmacy Drugs listed on Our Medical Provider Administered Specialty Drug List must be obtained through Our Specialty Pharmacy. See the **SPECIALTY PHARMACY** section for more information.

Home IV Therapy

Home IV therapy is covered and includes a combination of nursing, Durable Medical Equipment and IV pharmaceutical services that are delivered and/or administered intravenously in the home. Home IV Therapy includes services and supplies such as for Total Parenteral Nutrition (TPN), Antibiotic therapy, pain management and Chemotherapy. TPN received in the home is a covered benefit for the first 21 days following a Hospital discharge when it is determined to be Medically Necessary. Additional days may be allowed up to a maximum of 42 days per Benefit Year when preauthorized by Us.

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

Medical Foods

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

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

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

Hospice Care Services

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

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

Hospice Services include:

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

Human Organ and Tissue Transplant Services

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

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

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

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

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

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

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

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

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

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

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

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

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

Only those Human Organ and Tissue Transplants and directly related procedures specified in this section are Covered Services under this benefit. Benefits will only be provided for Covered Services and supplies furnished to the transplant recipient starting one day prior to a Covered Transplant Procedure and continuing at the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the In-Network Provider

agreement. At the end of this case rate/global time period benefits are provided under the **PHYSICIAN OFFICE SERVICES, INPATIENT SERVICES** and **OUTPATIENT SERVICES** sections, depending on where the service is performed and are not subject to the terms of this **HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES** section.

Other services

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

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

- When both the recipient and the donor are Our Members, each is entitled to the Covered Services specified in this section.
- When only the recipient is a Member, both the donor and the recipient are entitled to the Covered Services specified in this section.
- The donor benefits are limited to those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, grants, foundations, government programs, etc.
- If the donor is Our Member, and the recipient is not covered by Us, benefits will not be provided for the donor or recipient expenses.

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

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

Medical Supplies, Durable Medical Equipment, and Appliances

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

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

Medical and Surgical Supplies

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

Durable Medical Equipment

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

Prosthetic Devices

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

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

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

Benefits for prosthetic devices include:

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

Orthopedic Appliances

Purchase, fitting, needed adjustment, repairs, and replacements of Orthopedic Appliances and supplies that are rigid or semi-rigid supportive device and that limit or stop motion of a weak or diseased body part.

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

Hearing Aid Services

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

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

Dental Related Services

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

Outpatient Services, Physician Office Services, Emergency Care Services and Urgent Care Services for dental work and oral Surgery are covered if they are for the initial repair of an Accidental Injury to the jaw, sound natural teeth, or related body tissue, mouth or face if received within seventy-two (72) hours of the accident. Such dental services do not include dental restoration. All dental services received after seventy-two (72) hours following the accident are not covered. Injury as a result of chewing or biting is not considered an Accidental Injury.

Dental Anesthesia

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

Cleft Palate and Cleft Lip Conditions

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

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

Mental Health Care, Alcohol Dependency and Substance Dependency Services

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

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

Mental health care is coverage for conditions identified as mental disorders in the most current version of the International Classification of Diseases, in the chapter titled "Mental Disorders." Mental health conditions are those that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition. Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) care is covered under the mental health care benefit if the services are provided by a licensed mental health provider.

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

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

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

Preauthorizations. The member's provider should contact HMO Colorado's behavioral health administrator to determine medical necessity, appropriate treatment level and appropriate setting. Non-emergent inpatient services are subject to preauthorization notification guidelines. See the **MANAGED CARE FEATURES** heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization guidelines. HMO Colorado's behavioral health administrator must be notified for all emergency admissions by the next business day unless the member is unable to do so.

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

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

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

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

Retail Pharmacy/Mail Order Prescription Drugs

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

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

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

The Outpatient pharmacy benefits available under this Certificate are managed by the Pharmacy Benefits Manager (PBM). The PBM is the entity with which HMO Colorado has contracted to administer its prescription drug benefits. The PBM offers a nationwide network of Retail Pharmacies, a Mail-Service Pharmacy, a Specialty Pharmacy and clinical services. You may review the current formulary Prescription Drug list on Our website at www.anthem.com, under prescription benefits. You may also request a copy of the Formulary/drug list by calling our customer service department. The Formulary/drug list is subject to periodic review and amendment. Inclusion of a drug or related item on the Formulary/Prescription Drug list is not a guarantee of coverage.

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

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

We have established a Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs, determining the tier assignments of drugs, and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

The determination of tiers is made by Us based on clinical decisions provided by the P&T Committee, and where appropriate the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives and where appropriate, certain clinical economic factors.

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

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

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

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

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

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

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

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

Outpatient pharmacy benefits received from a In-Network pharmacy or Mail Service Pharmacy are limited to:

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

Each prescription is subject to a Copayment. If the prescription order includes more than one covered drug or supply, a separate Copayment is required for each covered drug or supply. The Copayment will be the lesser of your Copayment, or the Prescription Drug Maximum Allowed Amount. The Copayment will not be reduced by any discounts, rebates or other funds received by Us or the PBM from drug manufacturers, or similar vendors and/or funds received by Us and or the PBM. We will make no payment for any covered drug or supply unless the Prescription Drug Maximum Allowed Amount exceeds any applicable Copayment for which you are responsible. See *the Health Benefit Plan Description Form* to determine the associated Copayment.

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

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

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

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

Prescription Drugs will always be dispensed as ordered by your Provider and by applicable State Pharmacy Regulations. You may request, or your Provider may order, a Brand-Name drug. However, if a Generic drug is available, you will be responsible for the cost difference between the Generic and Brand-Name drug, in addition to your Generic Copayment. The cost difference between the Generic and Brand-Name drug does not contribute to your Out-of-Pocket Annual Maximum. By law, Generic and Brand-Name drugs must meet the same standards for safety, strength, and effectiveness. Using Generics generally saves money, yet provides the same quality. We reserve the right, at our discretion, to remove certain higher cost Generic drugs from this policy.

Mail Service Program

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

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

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

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

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

Specialty Pharmacy

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

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

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

The Outpatient Specialty Pharmacy benefits available under this certificate are provided by the PBM. The PBM is the entity with which HMO Colorado as contracted to administer its prescription drug benefits. The PBM Specialty Pharmacy is a full service Specialty Pharmacy which ships medications to you by overnight mail or common carrier for up to a 30-day supply (you cannot pick up your medication from the PBM Specialty Pharmacy). The PBM Specialty Pharmacy is not a Retail Pharmacy or a Mail Service Pharmacy. We have established a Pharmacy and Therapeutics (P&T) Committee, consisting of health care professionals, including nurses, pharmacists and physicians. The purpose of this committee is to assist in determining clinical appropriateness of drugs, determining the tier assignments of drugs, and advising on programs to help improve care. Such programs may include, but are not limited to, drugs utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drugs profiling initiatives and the like.

The determination of tiers is made by Us based on clinical decisions provided by the P&T Committee, and where appropriate the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter alternatives and where appropriate, certain clinical economic factors.

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

You may review the current Medical Provider Administered Specialty Drug List and Self-Administered Specialty Drug List on Our website at www.anthem.com. You may also request a copy of either list by calling our customer service department. Our Medical Provider Administered Specialty Drug List and Self-Administered Specialty Drug List are subject to periodic review and amendment. Inclusion of a drug or related item on either list is not a guarantee of coverage.

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

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

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

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

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

Prescription Drugs will always be dispensed as ordered by your Provider and by applicable State Pharmacy Regulations. You may request, or your Provider may order, a Brand-Name drug. However, if a Generic drug is available, you will be responsible for the cost difference between the Generic and Brand-Name drug, in addition to your Generic Copayment. The cost difference between the Generic and Brand-Name drug does not contribute to your Out-of-Pocket Annual Maximum. By law, Generic and Brand-Name drugs must meet the same standards for safety, strength, and effectiveness. Using Generics generally saves money, yet provides the same quality. We reserve the right, at our discretion, to remove certain higher cost Generic drugs from this policy.

Each prescription is subject to a Copayment. If the prescription order includes more than one covered drug or supply, a separate Copayment is required for each covered drug or supply. The Copayment will be the lesser of your Copayment, or the Prescription Drug Maximum Allowed Amount. The Copayment will not be reduced by any discounts, rebates or other funds received by Us or the PBM from drug manufacturers, or similar vendors and/or funds received by Us and or the PBM. We will make no payment for any covered drug or supply unless Our Prescription Drug Maximum Allowed Amount exceeds any applicable Copayment for which you are responsible. See the *Health Benefit Plan Description Form* to determine the associated Copayment.

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

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

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

You may also contact the Specialty Pharmacy PBM at:

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

Exception Process for Specialty Pharmacy Drugs

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

Clinical Trials

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

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

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

GENERAL EXCLUSIONS

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

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

1. That We determine are not Medically Necessary. Emergency medical care is not subject to this exclusion as long as such care meets the definition of emergency medical care, see the **Emergency Care and Urgent Care** section of this Certificate;
2. For care received from a Out-of-Network Provider, except for Emergency Care, Urgent Care or as preauthorized by Us as a Covered Service;
3. Received from an individual or entity that is not a Provider, as defined in this Certificate;
4. That are Experimental/Investigational or related to such, whether incurred before, in connection with, or subsequent to the Experimental/Investigational service or supply, as determined by Us;
5. To the extent they are available as benefits through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits under this Certificate will be coordinated with such governmental units to the extent required under existing state and/or federal laws;
6. For which benefits are payable under Medicare Part A and/or Medicare Part B, unless otherwise specified in this Certificate or as otherwise prohibited by federal law, as addressed in the section titled **Medicare** in **ADMINISTRATIVE INFORMATION**;
7. In excess of the Maximum Allowable Amount for Medical Supplies, durable medical equipment and appliances unless otherwise specified in this Certificate;
8. Incurred before your Effective Date;
9. Incurred after the termination date of this coverage unless otherwise specified in this Certificate;
10. For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Cosmetic Services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for Surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except where coverage of such procedures, services or supplies are specifically required by applicable law;
11. For services performed to maintain or preserve the present level of function or prevent regression of function for an illness, injury or condition that is resolved or stable;
12. For dental prosthesis and any treatment for teeth, gums, tooth or upper or lower jaw augmentation or reduction (orthognathic Surgery) and related service, unless otherwise specified in this Certificate;
13. Weight loss programs, whether or not they are pursued under medical or Physicians supervision, unless otherwise specified in this Certificate;
14. Treatment of obesity, except for surgical treatment of morbid obesity (bariatric surgery) up to the maximum benefit as listed on the *Health Benefit Plan Description Form*;
15. For care received in an emergency room which is not Emergency Care;
16. For research studies or screening examinations, unless otherwise specified in this Certificate;
17. For stand-by charges of a Physician;
18. Immunizations for travel.

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

44. For services or supplies primarily for educational, vocational, or training purposes, unless otherwise specified in this Certificate;
45. Services to reverse voluntarily induced sterility;
46. Services of any type for the treatment of infertility;
47. For Experimental infertility procedures and non-Medically Necessary infertility procedures including, but not limited to artificial insemination, In-Vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT);
48. For or related to services (including but not limited to speech therapy) for dysfunctions that are self-correcting such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting, learning disabilities, behavioral problems, hyperkinetic syndromes or mental retardation (except for Prescription Drugs for treatment of these conditions if Prescription Drugs are a covered benefit);
49. For personal hygiene services, self help devices that are not medical in nature, or services and supplies for comfort and convenience;
50. For care related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy;
51. Related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergetic synchronization technique (BEST), biofeedback, chelating agents (except for treatment of heavy metal poisoning) and iridology;
52. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas;
53. For self-help training and other forms of non-medical self care, unless otherwise specified in this Certificate;
54. For hair loss treatment, even if the hair loss is caused by a medical condition, except for alopecia areata or as otherwise specified in this Certificate;
55. For peripheral bone density scans;
56. For storage or other administrative costs, except when provided as part of the Inpatient Services and Human Organ and Tissue Transplant Services;
57. For medical, surgical services and appliances related to temporomandibular joint (TMJ) therapy regardless of Medical Necessity;
58. For the cost of donor sperm or donor eggs, storage costs for sperm or frozen embryos, or diagnostic tests to determine the effectiveness of a procedure designed to promote fertility or pregnancy;
59. Provided or billed by a residential treatment center, school, halfway house, custodial care facility for the developmentally disabled or outward bound program, even if psychotherapy is included;
60. For rolfing therapy, myotherapy or prolotherapy;
61. For ambulance transportation if you could have been transported by private automobile or by commercial or public transportation without endangering your health or safety;
62. For orthotics, orthopedic shoes and arch supports (except if you are diagnosed with diabetes);
63. For air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, wristlets, breast pumps, augmentative communication devices, surgical supports, and corsets or other articles of clothing, unless otherwise specified in this Certificate;
64. For items usually stocked in the home for general use like Band-Aids, thermometers and petroleum jelly.
65. Language training for educational, psychological or speech delays;
66. Diversional, recreational or vocational therapies such as hobbies, arts and crafts;
67. Sclerotherapy for the treatment of varicose veins in the lower extremities, including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing

treatment of varicose veins of the lower extremities with sclerotherapy. Treatment of telangiectatic dermal veins (spider veins) by any method.

68. For any services or supplies provided to a person not covered under the Certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another women for an infertile couple);
69. Cardiac rehabilitation home programs, on-going conditioning and maintenance;
70. Self-administered drugs purchased through or provided by a physicians office;
71. For massage therapy any manipulative techniques or procedures which are not generally accepted in a majority of states' Massage Therapy licensing boards. Massage therapy supplies including but not limited to lotions;
72. For acupuncture services primarily for the purpose of weight control, related to menstrual cramps and addiction including smoking cessation
73. For nutrition therapy or counseling except for diabetes as described in the **DIABETES MANAGEMENT SERVICES** section of this certificate.
74. Elective termination of pregnancy.

Human Organ and Tissue Transplant Services:

1. Human Organ and Tissue Transplant services that are performed at any Hospital that is not designated or approved by Us for the organ or tissue being transplanted;
2. If you are not a suitable candidate as determined by the Hospital designated and approved by Us to provide Human Organ and Tissue Transplant services;
3. For donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or for their respective family members or friends unless otherwise specified in this Certificate;
4. For any transplant, treatment, procedure, facility, equipment, drug, device, service or supply that requires federal or other governmental agency approval and such approval is not granted at the time services are provided, including any service or supply associated with or provided in follow-up;
5. For transplants of organs other than those listed in the **HUMAN ORGAN AND TISSUE TRANSPLANT** section of this Certificate including non-human organs;
6. Procurement of a donor organ which has been sold rather than donated;
7. Related to artificial and/or mechanical hearts or for subsequent services and supplies for a heart condition as long as any of the artificial or mechanical heart remains in place. This exclusion includes services for implantation, removal and complications.
8. For non-covered transportation and lodging expenses related but not limited to the following:
 - Alcohol, tobacco, other non food items;
 - Meals;
 - Child care;
 - Mileage within the medical transplant facility city;
 - Rental care, buses, taxis, or shuttle services, except as specifically approved by Us;
 - Frequent Flyer miles;
 - Coupons, vouchers, or travel tickets;
 - Prepayment or deposits;
 - Services for a condition that is not directly related, or a direct result, of the transplant;
 - Telephone calls;
 - Laundry;

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

Retail Pharmacy Prescription Drugs:

1. Prescription Drugs and supplies received from an Out-of-Network pharmacy;
2. Prescription Drugs and supplies received as an inpatient in a hospital or other covered inpatient facility, except where covered as part of the inpatient stay;
3. Non-legend Prescription Drugs;
4. Drugs prescribed for weight control or appetite suppression;
5. Medication or preparations used for cosmetic purposes to promote hair growth, prevent hair growth, or medicated cosmetics. These included but are not limited to Rogaine®, Viniqa®, and Tretinoin (sold under such brand names as Retin-A®);
6. Drugs not approved by the FDA;
7. Any new FDA approved drug product or technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA new drug approval or other applicable FDA approval. We may at Our sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology;
8. Any medications used to treat infertility;
9. Delivery charges for prescriptions;
10. Charges for the administration of any drug unless dispensed in the Physician's office or through Home Health Care;
11. Drugs which are provided as samples to the Provider;
12. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse;
13. Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of the **PRESCRIPTION DRUG** section;
14. Therapeutic devices or appliances, including support garments and other nonmedicinal supplies (regardless of intended use);
15. Nonprescription and over-the-counter drugs, including herbal or homeopathic preparations, and Prescription Drugs that have a clinically equivalent alternative, even if written as a prescription;
16. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) except for injectable insulin;
17. Prescription Drugs, which are dispensed in quantities or refill frequency which exceed the applicable limits established by Us, at Our sole discretion;
18. Refills of prescriptions in excess of the quantity prescribed by the Provider, or refilled more than one year from the date prescribed;
19. Prescription Drugs dispensed for the purpose of international travel;
20. Prescription Drugs which have been obtained through a Home Health Agency;
21. Replacement of lost or stolen Prescription Drugs.

Specialty Pharmacy Drugs

1. Specialty Pharmacy Drugs which are not provided through the specialty program, including but not limited to Specialty Pharmacy drugs that are provided through a Physician's office or Home Health Agency.
2. When benefits are provided under the Specialty Pharmacy benefits they will not be provided under the **Retail Pharmacy Prescription Drug** section of this certificate.
3. Outpatient prescription drugs or medications that are Specialty Pharmacy Drugs received from a Retail Pharmacy. You will pay the full cost of the Specialty Pharmacy Drug when received from a Retail Pharmacy since those services should have been received from a Specialty Pharmacy.

Chiropractic Therapy

1. Services for preventive, maintenance or well care;
2. Drugs, vitamins, nutritional supplements or herbs from a chiropractor;
3. Vocational, stroke, or long-term rehabilitation unless otherwise specified in this Certificate;
4. Hypnotherapy, behavior training, sleep therapy, or biofeedback;
5. Rental or purchase of Durable Medical Equipment unless otherwise specified in this Certificate;
6. Treatment primarily for purpose of weight control;
7. Laboratory services from a chiropractor;
8. Thermography, hair analysis, heavy metal screening of mineral studies;
9. Inpatient services from a chiropractor;
10. Manipulation under anesthesia;
11. Treatment of non-neuromusculoskeletal disorders;
12. Advance diagnostic services such as MRI, CT, EMG, SEMG, and NCV.

Clinical Trials

1. Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
2. Any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
3. Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;
4. An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;
5. Costs for the management of research relating to the clinical trial or study;
6. Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under this Certificate; or
7. Any service or procedure related to the diagnosis, treatment or prevention of complications related to a clinical trial.

ADMINISTRATIVE INFORMATION

Insurance Premiums

How Premiums are Established and Changed - Premiums are the monthly charges you and/or the employer must pay Us to establish and maintain coverage. We determine and establish the required Premiums.

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

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

How to File Claims

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

If an Out-of-Network Provider does not bill Us directly, you must file the claim. To obtain claim forms, contact Our customer service department or obtain from our web site at www.anthem.com. If We do not furnish a claim form to you within 15 days of your request, you may submit written proof of the claim and will be considered to have complied with the requirements of this Certificate for submitting a claim. You must complete the claim form and attach the itemized bill from the Provider. Balance due statements, cash register receipts and cancelled checks are not accepted. All information on the claim form and itemized bill must be readable. When traveling outside the country, you should obtain itemized bills translated to English. Charges for Covered Services should be stated in terms of United States currency. To determine the United State currency amount, use the exchange rate as it was on the date you received care. If information is missing on the claim form or is not readable, the form will be returned to you. The information contained on the itemized bills will be used to determine benefits, so it must support information reported on the submitted claim form. The claim form contains detailed instructions on how to complete the form and what information is necessary.

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

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

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

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

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

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

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

You will be entitled to benefits for health care services you received either inside or outside the geographic area We serve if this Certificate covers those health care services. Due to variations in Host Blue medical practice protocols, you may also be entitled to benefits for some health care services obtained outside the geographic area We serve, even though you might not otherwise have been entitled to benefits if you had received those health care services inside the geographic area We serve. But in no event will you be entitled to benefits for health care services wherever you received them that are specifically excluded or limited from coverage by this Certificate.

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

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

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

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

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

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

General Provisions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Workers' Compensation

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

Services and supplies resulting from work-related illness or injury are not a benefit under this Certificate, except for corporate officers who have opted out of Workers' Compensation coverage, pursuant to state or federal law, prior to

the illness or injury. This exclusion from coverage applies to expenses resulting from occupational accident(s) or sickness(es) covered under the following:

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

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

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

Automobile Insurance Provisions

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

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

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

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

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

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

We will also pay benefits under the terms of the Certificate for injuries you sustain if as a non-owner-operator, passenger or pedestrian involved in a motor vehicle accident if those injuries are not covered by a complying policy. In that event, We may exercise the rights found in the **ADMINISTRATIVE INFORMATION** section, under the heading *Third Party Liability: Subrogation and Right of Reimbursement*.

Third Party Liability: Subrogation and Right of Reimbursement

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

Subrogation

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

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

Right of Reimbursement

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

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

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

- The amount We paid is not repaid or otherwise recovered by Us; or
- You fail to cooperate or otherwise fulfill your duties, as described in this Certificate.
- In the event you, your legal representative, or a beneficiary fails to disclose to Us the amount of any settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Certificate.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of any settlement, whichever is less, directly from the providers to whom We have made payments, to the extent not prohibited by law. In such a circumstance, it may then be the obligation of you, your legal representative, or beneficiary to pay the provider the full outstanding amount, and We would not have any obligation to pay the provider.

- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make to you or the recovering party whole.

The Member's Duties

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

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

Duplicate Coverage and Coordination of Benefits

We coordinate benefits when you have duplicate coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMPLAINTS, APPEALS AND GRIEVANCES

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

Complaints

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

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

Appeals

Your Appeal must be submitted in writing. While We encourage you to file Appeals within 60 days of the adverse benefit determination, your written Appeal must be received by Us within 180 days of the adverse benefit determination. Appeals may be for pre-service denials or post-service denials. We will assign a customer advocate to assist you in the Appeal process. You must send written appeals to the following address:

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

An Appeal may be filed with or without first submitting a complaint. In the Appeal, you must state plainly the reason(s) why the claim or requested service or supply should not have been denied. You should include any documents not originally submitted with the claim or request for the service or supply and any information that may have a bearing on our decision.

For a thorough, unbiased review, you may access two internal levels of Appeal. In the case of a benefit denial based on utilization review, an independent external review Appeal is also available to you. For pre-service denials based on utilization review, an expedited Appeal and expedited independent external review may be available in certain circumstances.

You may designate a representative (e.g., your Physician or anyone else of your choosing) to file any level of Appeal review with us on your behalf. You must give this designation to us in writing.

The Appeals process is governed by laws and regulations, and may be modified from time to time by Us as those laws may require. A more detailed description of the Appeals process and the decision timeframes is set forth in our Appeals guide. This guide is available through our website or may be obtained free of charge by calling customer service.

Grievances

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

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

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

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 Certificate 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, provided however, that no formal discovery shall be allowed, unless agreed to by the parties. You may obtain a copy of the Rules of Arbitration by calling Our customer service department. The law of the state in which the policy was issued and delivered to you shall govern the dispute. The arbitration decision is binding on both you and Us. Judgment on the award made in arbitration may be enforced in any court with proper jurisdiction. If any person subject to this arbitration clause initiates legal action of any kind, the other party may apply for a court of competent jurisdiction to enjoin, stay or dismiss any such action and direct the parties to arbitrate in accordance with this provision.

Damages, if any, are limited to the amount of the benefit payment in dispute plus reasonable costs. We are not liable for punitive damages or attorney fees.

Legal Action

Before you take legal action on a claim decision, you must first follow the process outlined under the **Appeals** heading in this section and you must meet all the requirements of this Certificate.

No action in law or in equity shall be brought to recover on this Certificate before the expiration of 60 calendar days after a claim has been filed in accordance with the requirements of this Certificate. No such action shall be brought at all unless brought within three years after claim has been filed as required by the Certificate.

GLOSSARY

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

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

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

Acute Rehabilitation Therapy - inpatient rehabilitation therapy that is required for a short period of time. Acute rehabilitation therapy services are unrelated to acute hospital medical or surgical care.

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

Alcoholism Treatment Center - an accredited or licensed Hospital, or any other public or private facility or portion thereof providing services especially for the treatment of Substance Dependency which is licensed by the Colorado Department of Human Services for those services.

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

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

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

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

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

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

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

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

- General Anesthesia, also known as total body Anesthesia, causes the patient to become unconscious or “put to sleep” for a period of time
- Local Anesthesia causes loss of feeling or numbness in a specific area and is usually injected with a local anesthetic drug such as Lidocaine

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

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

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

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

Autism Services Provider - any person who provides direct services to a person with Autism Spectrum Disorder, is licensed, certified, or registered by the applicable state licensing board or by a nationally recognized organization, and who meets one of the following:

- Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology, is actively licensed by the state board of medical examiners, and has one year of direct experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders;
- Has a doctoral degree in one of the behavioral or health sciences and has completed one year of experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders;
- Has a master's degree or higher in behavioral sciences and is nationally certified as a "board certified behavior analyst" or certified by a similar nationally recognized organization;
- Has a master's degree or higher in one of the behavior or health sciences, is credentialed as a related services provider, and has completed one year of direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders. For the purposes of this sub-subparagraph (d), "related services provider" means a physical therapist, occupational therapist, or speech therapist.
- Has a baccalaureate degree or higher in behavioral sciences and is nationally certified as a "board certified associate behavior analyst" or certified by a similar nationally recognized organization.

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

Autism Treatment Plan - a plan developed for an individual by an Autism Services Provider and prescribed by a licensed physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation for an individual consisting of the individual's diagnosis; proposed treatment by type, frequency, and anticipated treatment; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. The treatment plan is developed in accordance with the patient-centered Medical Home as defined in state law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Cold Therapy - the application of cold to decrease swelling, pain or muscle spasm.

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

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

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

Consultation/Second Opinion - a service provided by another Physician who gives an opinion about the treatment of your condition. The consulting Physician often has specialized skills that are helpful in diagnosing or treating the illness or injury.

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

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

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

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

Covered Services - services, supplies or treatments which are:

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

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

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

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

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

Dental Services - services performed for treatment of conditions related to the teeth or structures supporting the teeth.

Dependent - a Subscriber's legal spouse, or child as defined in the **MEMBERSHIP** section of this Certificate under the heading **Dependents**.

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

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

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

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

Effective Date - the date coverage under this Certificate begins.

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

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

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

Experimental/Investigational -

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hemodialysis - the treatment of an acute or chronic kidney ailment during which impurities are removed from the blood with dialysis equipment.

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

Also referred to as "HMOC".

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

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

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

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

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

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

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

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

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

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

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

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

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

Intractable Pain - a pain state in which the cause of the pain cannot be removed and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts, including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area, system or organ of the body perceived as the source of the pain.

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

In-Vivo - within the living body.

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

Long-Term Acute Care Facility (LTC) - an institution that provides an array of long-term critical care services if you have serious illnesses or injuries. Long-Term Acute Care is provided for Members with complex medical needs. These include Members with high-risk pulmonary condition who have ventilator or tracheotomy needs Members, medically unstable

Members, extensive wound care needs or post operative Surgery wound care needs, and Members with low level closed head injuries. Long-Term Acute Care Facilities do not provide care for low intensity patient needs.

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

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

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

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

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

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

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

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

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

Medical home - an appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, mental health care, oral health care, and related services for a dependent child. A medical home may also be referred to as a health care home. If a dependent child's medical home is not a primary medical care provider, the dependent child must have a primary medical care provider to ensure that the primary medical care needs are appropriately addressed. All medical homes shall ensure, at a minimum, the following:

- Health maintenance and preventative care
- Anticipatory guidance and health education
- Acute and chronic illness care
- Coordination of medications, specialists, and therapies
- Provider participation in hospital care; and
- Twenty-four-hour telephone care

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

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

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

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

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

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

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

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

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

Nephritis - infection or inflammation of the kidney.

Nephrosis - condition in which there are degenerative changes in the kidneys without the occurrence of inflammation.

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

OMT - an acronym for Osteopathic Manipulative Therapy, a hands-on modality of evaluation, diagnosis, and treatment using palpation of the body’s tissues and musculoskeletal system with a variety of therapeutic techniques involving fascia, muscles, and joints to help resolve both acute and chronic musculoskeletal injuries.

Open Enrollment - the 31 days before to a group’s Anniversary Date. During this period, you may enroll yourself and your Dependents for coverage or change coverage options, if this option is available.

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

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

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

Out-of-Network - a term for Providers or facilities that do not enter into a network agreement with Us. Services received from an Out-of-Network Provider, usually result in a higher out-of-pocket expense to you than services rendered by an In-Network Provider.

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

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

Paraprofessional - a trained colleague who assists a professional person, such as a radiology technician.

Primary Care Physician (PCP) - an acronym for primary care Physician, a Physician who has contracted with Us to supervise, coordinate and provide initial and basic care to you.

Physical and Medical Rehabilitation - care that includes a minimum of three hours of therapy, e.g., Speech Therapy, respiratory therapy, Occupational Therapy and/or Physical Therapy, and often some weekend therapy. Inpatient Medical Rehabilitation is generally provided in a rehabilitation section of a Hospital or a freestanding facility. Some skilled nursing facilities have "rehabilitation" beds.

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

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

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

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

Prescription drugs - Prescription Drugs include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Reconstructive Surgery - in this Certificate reconstructive surgery includes those procedures that are intended to address a significant variation from normal related to accidental injury, disease, trauma, treatment of a disease or congenital defect.

Recovery – 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, no-fault, personal injury protection, or any other insurance coverage, as a result of injury or illness to the Member. Regardless of how the Member, the Member's legal representative, or beneficiary or any agreement may characterize the money received, it shall be subject to the **THIRD PARTY LIABILITY: SUBROGATION AND RIGHT OF RECOVERY** provisions of this Certificate.

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

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

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

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

Second Opinion - a visit to another Professional Provider (following a first visit with a different Provider) for review of the first Provider's opinion of proposed Surgery or treatment.

Second Surgical Opinion - a mechanism used by Managed Care organizations to reduce unnecessary Surgery by encouraging individuals to seek a Second Opinion before specific elective surgeries. In some cases, the health coverage may require a Second Opinion before a specific elective Surgery.

Self-Administered Specialty Drug List - a list of Specialty Pharmacy Drugs as determined by HMO Colorado which must be obtained from the In-Network Specialty Pharmacy PBM and which are billed under the pharmacy benefit.

Service Area - the geographic area where we are licensed to conduct business.

Skilled Nursing Care Facility (SNF) - an institution that provides you with skilled nursing care, e.g., therapies and protective supervision if you have an uncontrolled, unstable or chronic condition. Skilled nursing care is provided under medical supervision to carry out nonsurgical treatment of chronic diseases or convalescent stages of acute diseases or injuries. Skilled nursing facilities do not provide you with care for high intensity medical needs, or if you are medically unstable.

Special Care Units - special areas of a Hospital with highly skilled personnel and special equipment to provide Acute Care, with constant treatment and observation.

Specialist - a professional, usually a Physician, devoted to a specific disease, condition or body part. Examples include, but are not limited to psychiatrist, orthopedist, obstetrician, gynecologist and cardiologist.

Specialty Pharmacy - a pharmacy that is designated by Anthem, other than a Retail Pharmacy, mail-order, or other specialty pharmacy that provides high cost, biotech drugs which are usually injected, oral, infused or inhaled and used for the treatment of acute or chronic diseases.

Specialty Pharmacy Drugs - these are high-cost, injectable, infused, oral or inhaled medications as listed on the Medical Provider Administered Drug List and the Self-Administered Specialty Drug List that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at a Retail Pharmacy.

Speech Therapy (also called Speech Pathology) - services used for the diagnosis and treatment of speech and language disorders. A licensed and accredited speech/language pathologist must perform Speech Therapy.

Spouse - a Subscriber's legal Spouse.

Stabilize - the provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- Your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- Your transfer from an emergency department or other care setting to another facility; or
- Your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Step Therapy - process of first requiring the use of designated medication over others for treatment as supported by clinical practice guidelines.

Sub-Acute Rehabilitation - inpatient rehabilitation therapy that has a duration in-between acute (short-term) and chronic (long-term) and includes a minimum of one hour of rehabilitation therapy per day.

Subcontractor – We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs and Mental Health and Alcohol Dependency or Substance Dependency services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer services duties on Our behalf.

Subscriber - the Member in whose name the membership with Us is established.

Substance Dependency - means alcoholism, drug and other substance abuse. Alcoholism, and substance abuse are conditions brought about when an individual uses alcohol, drugs or other substances in such a manner that his or her health is impaired and/or ability to control actions is lost.

Surgery - any variety of technical procedures for treatment or diagnosis of anatomical disease or injury, including, but not limited to cutting, micro Surgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, and other invasive procedures. Covered surgical services also include usual and related Anesthesia and pre- and post-operative care, including recasting.

Surgical Assistant - an assistant to the primary surgeon who provides required surgical services during a covered surgical procedure. We, at its sole discretion, determine which surgeries do or do not require a Surgical Assistant.

Therapy Services - treatments or the application of remedies for diseases, conditions or injuries.

Therapeutic Care - for purposes of the **Autism Services** section of this Certificate, Therapeutic Care means services provided by a speech therapist, an occupational therapist registered to practice occupational therapy, a physical therapist licensed to practice physical therapy, or an Autism Services Provider. Therapeutic care includes, but is not limited to, speech, occupational, and applied behavior analytic and physical therapies.

Ultrasound - a radiology imaging technique that uses high frequency sound waves to obtain a visual image of internal body organs or the fetus in a pregnant woman.

Urgent Care -an unexpected episode of illness or an injury requiring treatment that cannot reasonably be postponed for regularly scheduled care but which is not considered an emergency.

Urgent Care Center - an office or facility where care is provided for individuals who require immediate medical attention but whose condition is not life-threatening (non-Emergency).

Utilization Management —a process of integrating review of medical services and Care Management in a cooperative effort with other parties, including patients, Physicians, and other health care Providers and payers.

Utilization Review — a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or settings. Techniques include ambulatory review, prospective review, Second Opinion, certification, concurrent review, Care Management, Discharge Planning and/or retrospective review. Utilization Review also includes reviews to determine coverage. This is based on whether or not a procedure or treatment is considered Experimental/Investigational in a given circumstance (except if it is a specifically excluded under this Certificate), and review of your medical circumstances when such a review is necessary to determine if an exclusion applies in a given situation.

Well-Child Visit — a Physician visit that includes the following components: an age-appropriate physical exam, history, anticipatory guidance, and education (e.g., examining family functioning and dynamics, injury prevention counseling, discussing dietary issues, reviewing age-appropriate behaviors, etc.), and assessment of growth and development. For older children, a Well-Child Visit also includes safety and health education counseling.

X-ray and Radiology Services — services including the use of radiology, nuclear medicine and Ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.