

**019K-0717**

A Guide to Your Benefits

*You’ve made a good decision in choosing BlueAdvantage HMO*

*with Point of Service (POS) Rider on the Essential Formulary*

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products are underwritten by HMO Colorado, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association

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

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

COLGHMONGF CO BA1 10-200 (Rev. 01/17)



### PART A: TYPE OF COVERAGE

**Colorado Community College System BlueAdvantage Point-of-Service Plan Effective July 1, 2017**

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| **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 copayments options reflect the amount the covered person will pay.

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **4. DEDUCTIBLE TYPE 2** | Benefit Year | Benefit Year |
| **4a. ANNUAL DEDUCTIBLE2a**  **a) Individual** | No Deductible | $500 |
| **b) Family** | No Deductible | $1,000 |
|  |  | Some Covered Services have a maximum benefit of days, visits or dollar amounts allowed. 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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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| 1. **OUT-OF-POCKET ANNUAL MAXIMUM3**    1. **Individual**    2. **Family**    3. **Is deductible included in the out-of- pocket maximum?** | $4,500 Copayments and Coinsurance are included in the Out-of-Pocket Annual Maximum.  $9,000 Copayments and Coinsurance are included in the Out-of-Pocket Annual Maximum.  Not applicable  Some covered services have a maximum numbers of days, visits or dollar amounts. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied. | $6,000 Copayments and Coinsurance are included in the Out-of-Pocket Annual Maximum  $12,000 Copayments and Coinsurance are included in the Out-of-Pocket Annual Maximum  Yes  Some covered services have a maximum number of days, visits or dollar amounts. 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, you will still be responsible for paying the difference between the Maximum Allowed Amount and the Non-Participating Providers Billed Charges.  The amounts you pay for Out-of-Network Covered Services are in addition to your  balance billing costs. |
| **6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE** | No lifetime maximum for most Covered Services. Bariatric surgery has a per occurrence maximum benefit of $15,000 per member for services received from a designated facility. Bariatric surgery has a per occurrence maximum benefit of $1,500 per member for services not received from a designated facility. Total per occurrence maximum benefit shall not exceed $15,000 per member in- and out-of-network  combined. | No lifetime maximum for most Covered Services. Bariatric surgery has a per occurrence maximum benefit of $1,500 per member for services not received from a designated facility. Total per occurrence maximum benefit shall not exceed $15,000 per member in- and out-of-network 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 Services. |
| **7B. With respect to network plans, are all**  **the providers listed in 7A accessible to me through my primary care physician?** | Yes | Yes |
| 1. **MEDICAL OFFICE VISITS4**    1. **Primary Care Providers**    2. **Specialists** | $35 Copayment per visit  $60 Copayment per visit | You pay 30% after Deductible You pay 30% after Deductible |

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| 1. **PREVENTIVE CARE**    1. **Children’s services**    2. **Adult 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, contraceptives, immunizations and office visits; and are not subject to coinsurance or deductible. | $50 Copayment per visit for PCP and $100 Copayment per visit for Specialist.  Copayment includes services provided as preventive care.  $50 Copayment per visit for PCP and $100 Copayment per visit for Specialist.  Copayment includes services provided as preventive care. For covered colonoscopy facility services, you pay $500 Copayment.  Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, contraceptives, immunizations and office visits; and are not subject to coinsurance or deductible. |
| 1. **MATERNITY**    1. **Prenatal care**    2. **Delivery & inpatient well baby care5** | $60 Copayment for the first prenatal care office visit/delivery from the Doctor  $700 copayment per day, up to a maximum copayment of $2,100 per admission | You pay 30% after Deductible  You pay 30% after Deductible |
| **11. PRESCRIPTION DRUGS**  **Level of coverage and restrictions on prescriptions6** |  |  |
| **a) Inpatient care** | Included with the inpatient Hospital Copayment (see line 12) | Included with inpatient Hospital Copayment (see line 12) |
| **b) Outpatient care** | **Retail Pharmacy Drugs** - Tier 1 $15 Copayment, tier 2 $50 Copayment, tier 3  $80 Copayment, tier 4 30% Copayment, per prescription at a participating pharmacy up to a 30-day supply. For tier 4 retail Pharmacy Drugs, the maximum Copayment per prescription is $100 per 30- day supply. | Not covered |
|  | Diabetic medication and supplies will be covered under the tier 1 $15 copayment. |  |
|  | **Specialty Pharmacy Drugs** - Tier 1 $15 Copayment, tier 2 $50 Copayment, tier 3  $80 Copayment, tier 4 30% Copayment, per prescription from our Specialty Pharmacy up to a 30-day supply. For tier 4 Specialty Pharmacy Drugs the maximum Copayment per prescription is $100 per 30- day supply from our Specialty Pharmacy. Specialty Pharmacy Drugs are not available at a Retail Pharmacy or from a Home Delivery pharmacy. | Not covered |
|  | Diabetic medication and supplies will be covered under the tier 1 $15 copayment. |  |

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **c) Home Delivery Service** | **Home Delivery Pharmacy Drugs** - Tier 1  $15 Copayment, tier 2 $100 Copayment, tier 3 $160 Copayment per prescription through the Home Delivery Pharmacy up to a 90-day supply. For the tier 4, Specialty Pharmacy Drugs are not available through the Home Delivery Pharmacy.  Diabetic medication and supplies will be covered under the tier 1 $15 copayment.  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 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. We reserve the right, at our discretion, to remove certain higher cost Generic Drugs from this coverage. For drugs on our approved list, call member  services at 1-800-542-9402. | Not covered |
| **12. INPATIENT HOSPITAL** | $700 copayment per day, up to a maximum copayment of $2,100 per admission | You pay 30% after Deductible |
| **13. OUTPATIENT/AMBULATORY SURGERY** | $375 Copayment per surgery at a free- standing non-hospital based facility.  $700 Copayment per surgery at a hospital based facility. | You pay 30% after Deductible  You pay 30% after Deductible |
| 1. **DIAGNOSTICS**    1. **Laboratory & x-ray**    2. **MRI, nuclear medicine, and other high-tech services** | No Copayment (100% covered)  $100 Copayment per procedure for MRI/MRA/CT/PET scans at a free-standing non-hospital based facility  $150 Copayment per procedure for MRI/MRA/CT/PET scans at a hospital based facility. | You pay 30% after Deductible You pay 30% after Deductible  You pay 30% after Deductible |
| **15. EMERGENCY CARE 7, 8** | $300 Copayment per emergency room visit. Copayment is waived if admitted. Care is covered In or Out-of-Network. | Out-of-network care is paid as In-Network |
| **16. AMBULANCE** | $50 Copayment per trip for ground or air ambulance. Copayment is waived if admitted. Care is covered In or Out-of- Network. | Out-of-network care is paid as In-Network |
| **17. URGENT, NON-ROUTINE, AFTER HOURS CARE** | $60 Copayment per urgent care visit.  Urgent care may be received from your PCP or from an urgent care center. Care is | You pay 30% after Deductible |

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
|  | covered In Network or Out-of-Network. |  |
| 1. **MENTAL HEALTH CARE, ALCOHOL & SUBSTANCE ABUSE CARE**    1. **Inpatient care**    2. **Outpatient care** | $700 copayment per day, up to a maximum copayment of $2,100 per admission  No Copayment (100% covered) | You pay 30% after Deductible  You pay 30% after Deductible |
| 1. **PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY**    1. **Inpatient**    2. **Outpatient** | $700 copayment per day, up to a maximum copayment of $2,100 per admission. Up to 30 inpatient rehab days per benefit year In and Out-of-Network combined.  $35 Copayment per visit for PCP  $60 Copayment per visit for specialist Up to 20 visits each for physical, occupational and speech therapy per benefit year In and Out-of-Network combined. From birth until the Member’s sixth birthday, benefits are provided as required by applicable law. | You pay 30% after Deductible. Up to 30 inpatient rehab days per benefit year In and Out-of-Network combined.  You pay 30% after Deductible. Up to 20 visits each for physical, occupational and speech therapy per benefit year In and Out-of-Network combined, From birth until the Member’s sixth birthday, benefits are provided as required by applicable law. |
| **20. DURABLE MEDICAL EQUIPMENT & OXYGEN** | No Copayment (100% covered).  One wig following cancer treatment up to a  $500 benefit maximum. | You pay 30% after Deductible.  One wig following cancer treatment up to a  $500 benefit maximum. |
| 1. **ORGAN TRANSPLANTS**    1. **Inpatient**    2. **Outpatient** | $700 copayment per day, up to a maximum copayment of $2,100 per admission  $35 Copayment per visit for PCP  $60 Copayment per visit for specialist  Transportation and lodging services are limited to a maximum benefit of $10,000 per Transplant Benefit Period; unrelated donor searches are limited to a maximum benefit of $30,000 per Transplant Benefit Period. | Covered as In-Network when preauthorized and delivered in an HMO Colorado organ transplant facility. |
| **22. HOME HEALTH CARE** | No Copayment (100% covered). Up to 100 visits per benefit year combined In and Out-of-Network. | You pay 30% after Deductible. Up to 100 visits per benefit year combined In and Out-of-Network. |
| **23. HOSPICE CARE** | No Copayment (100% covered) | You pay 30% after Deductible |
| **24. SKILLED NURSING FACILITY CARE** | No Copayment (100%) covered. Up to 100 days per benefit year In and Out-of- Network combined. | You pay 30% after Deductible. Up to 100 days per benefit year In and Out-of- Network combined. |
| **25. VISION CARE** | Vision benefits can be found on the separate Anthem Vision Summary and Benefit Booklet | Vision benefits can be found on the separate Anthem Vision Summary and Benefit Booklet |
| **26. CHIROPRACTIC CARE** | $35 Copayment per visit. Up to 20 visits per benefit year in and out of network  combined. | Covered person pays 30% after deductible. Up to 20 visits per benefit year in and out  of network combined |

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **27. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)** | **Retail Health Clinic**  $40 Copayment per office visit. | Not Covered |
|  | **Hearing Aids**  Benefit level determined by place of service. Hearing aids are covered up to age 18 and are supplied every 5 years, except as required by law. | **Hearing Aids**  Benefit level determined by place of service. Hearing aids are covered up to age 18 and are supplied every 5 years, except as required by law. |
|  | **Treatment of Autism Spectrum Disorders**  Benefit level determined by type of service provided. | **Treatment of Autism Spectrum Disorders**  Benefit level determined by type of service provided. |
|  | **Osteopathic Manipulative Therapy** Osteopathic manipulative therapy (OMT) is limited to a maximum of 6 outpatient visits per benefit year In and Out-of-Network combined. | **Osteopathic Manipulative Therapy** Osteopathic manipulative therapy (OMT) is limited to a maximum of 6 outpatient visits per benefit year In and Out-of-Network combined. |
|  |  | A Member may also choose to receive Covered Services from a provider who is **not** in the HMO Colorado network. |

### PART C: LIMITATIONS AND EXCLUSIONS

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| **28. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. 10** | Not applicable; plan does not impose limitation periods for pre- existing conditions. |
| **29. EXCLUSIONARY RIDERS. Can an individual’s specific, pre-**  **existing condition be entirely excluded from the policy?** | No |
| **30. HOW DOES THE POLICY DEFINE A “PRE-EXISTING CONDITION”?** | Not applicable. Plan does not exclude coverage for pre-existing conditions. |
| **31. 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**

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **32. Does the enrollee have to obtain a referral**  **and/or prior authorization for specialty care in most or all cases?** | No | No |
| **33. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?** | Yes, the Doctor who schedules the procedure or Hospital care is responsible  for obtaining the Preauthorization. | Yes, you are responsible for obtaining Preauthorization unless the Provider  participates with Us. |
| **34. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?** | No | Yes, you will be responsible for paying the difference between the Maximum Allowed Amount and the Non-  Participating Provider’s Billed Charges (sometimes called “balance billing”).  The amounts you pay for Out-of-Network Covered Services are in addition to you balance billing costs.  . |
| **35. What is the main customer service number?** | 1-800-542-9402 | |

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **36. Whom do I write/call if I have a complaint or want to file a grievance?11** | HMO Colorado, Complaints and Appeals 700 Broadway  Denver, CO 80273  1-800-542-9402 | |
| **37. 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 | |
| **38. 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 COLGHMONGF\_COLGPOSNGF Group – Large | |
| **39. 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 or benefit 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 should 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.

4 Medical office visits include physician, mid-level practitioner, and specialist visits.

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 all services delivered in an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent layperson 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 Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

# Cancer Screenings

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

# Pap Tests

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

# Mammogram Screenings

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

# Prostate Cancer Screenings

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

# Colorectal Cancer Screenings

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

The information above is only a summary of the benefits described. The Booklet includes important additional information about limitations, exclusions and covered benefits. The Schedule of Benefits (Who Pays What) section includes additional information about Copayments, Deductibles and Coinsurance. If you have any questions, please call Our member services department at the phone number on the Schedule of Benefits form.

## NOTICE OF PROTECTION PROVIDED BY

**LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION**

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

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

The basic protections provided by the Association are:

* Life Insurance
* $300,000 in death benefits
* $100,000 in cash surrender or withdrawal values
* Health Insurance
  + $500,000 in hospital, medical and surgical insurance benefits
  + $300,000 in disability insurance benefits
  + $300,000 in long-term care insurance benefits
  + $100,000 in other types of health insurance benefits
* Annuities
  + $250,000 in withdrawal and cash values

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

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

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association’s website [http://colorado.lhiga.com,](http://colorado.lhiga.com/) emai[l jkelldorf.com](mailto:jkelldorf@aol.com) or contact:

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| Colorado Life and Health Insurance Protection Association  P.O. Box 36009 Denver, CO 80236  (303) 292-5022 | Colorado Division of Insurance 1560 Broadway, Suite 850  Denver, CO 80202  (303) 894-7499 |

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

**Cancer Screenings**

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

### Pap Tests

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

### Mammogram Screenings

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

### Prostate Cancer Screenings

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

### Colorectal Cancer Screenings

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

# Additional Federal Notices

## Statement of Rights under the Newborns’ and Mothers’ Health Protection Act

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

## Statement of Rights under the Women’s Cancer Rights Act of 1998

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

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

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

## Coverage for a Child Due to a Qualified Medical Support Order (“QMCSO”)

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

## Mental Health Parity and Addiction Equity Act

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

## Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your Dependents’ other coverage). However, you must request enrollment within 31 days after your or your Dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

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

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

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

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

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

## Statement of ERISA Rights

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

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide you the materials and pay you up to $110 a day until you receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If plan fiduciaries misuse the plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order you to pay these expenses, for example, if it finds your claim is frivolous. If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

# Contact Us

This rider works in combination with your HMO Booklet. Please review your Booklet and this rider to become familiar with your benefits, including what is not covered. By learning how coverage works, you can help make the best use of your benefits.

Your BlueAdvantage HMO Booklet 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 Booklet 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.

For questions about coverage, please visit Our website or call Our member services department. The website address is [www.anthem.com](http://www.anthem.com/) and the toll-free member services number is located on the *Schedule of Benefits* section found in this Booklet or the Health Benefit ID card mailed to your home.

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



Mike Ramseier

President and General Manager HMO Colorado

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**How to Access Your Services and Obtain Approval of Benefits**

This Point-of-Service rider is designed to give you the choice of getting Covered Services outside of your BlueAdvantage HMO Plan rules. For services that are covered under this rider, you may get those services from Out-of-Network Providers. In other words, you choose the level of coverage received at the “point of service.” This BlueAdvantage Point-of-Service Rider does not restrict or interfere with your right to select a hospital or to choose an attending Doctor, however they may not be covered.

If you obtain nonemergency care from Out-of-Network Providers, Medically Necessary services may be available as “point-of- service” benefits under this rider, subject to Deductible and Coinsurance. To learn more, read your *Schedule of Benefits*.

Note: Many Covered Services require Precertification. More information on Precertification is found under the heading of Precertification that is below.

Not all Covered Services that are described in the BlueAdvantage HMO Booklet are covered under this rider. See this rider under the section of “Limitations/Exclusions (What is not Covered)” for a list of services that are not covered.

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

### 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 Booklet are used to deter- mine whether services are covered under this rider. The only exception is when they are addressed in this rider. You will receive the highest level of coverage by following the procedures outlined in the BlueAdvantage HMO Booklet and using the HMO Provider network. HMO Providers are considered In-Network Providers.

If you receive services that are not given by an In-Network Provider or that are given without Our authorization, these services may be eligible for coverage under this rider. Covered Services under this rider are subject to your Benefit Period Deductible and Coinsurance unless otherwise specified in this rider or in the Schedule of Benefits. Not all services that are covered by the BlueAdvantage HMO Booklet are covered under this rider.

If you get your care from an In-Network Provider you receive full BlueAdvantage HMO Plan benefits, according to the terms of the BlueAdvantage HMO Booklet. Emergency Care and Urgent Care are covered at the In-Network level.

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

**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. Your Provider choice, Participating or Non-participating 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. You can reduce your out-of-pocket expenses by using Participating Providers. Those with no agreement are called Non-Participating Providers.

If you do not have a current directory, contact member services 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 member 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.

### Participating Providers

Participating Providers have a network agreement with Us for this health benefit plan. When you visit a Participating Provider you have lower out-of-pocket expenses. Your Out-of-Network Cost Sharing responsibilities to Participating Providers may be found on the *Schedule of Benefits* under the “Out-of Network” heading. You need to check to see if your Provider is a Participating Provider before your visit. To do that, you can check Our website or call Our member services.

We do not guarantee that a Participating Provider is available for all services and supplies covered under this rider. For some services and supplies, We may not have arrangements with Participating Providers.

Sometimes you may need to travel a reasonable distance to get care from a Participating Provider. This does not apply if care is for an Emergency. If you choose to obtain the service from a Non-Participating Provider rather than the Participating Provider, you will need to pay for any charges from the Non-Participating Provider that are over Our Maximum Allowed Amount. The Maximum Allowed Amount is the most We will allow for a Covered Service

### Nonparticipating Providers

Providers who have not signed a Participating 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 *Schedule of Benefits* under the “Out-of-Network” heading.

We will not deny or restrict Covered Services just because you get treatment from a Non-Participating Provider; however, you may have to pay more. The Cost Sharing for Covered Services from a Non-Participating Provider may be larger. Also, Non-Participating Providers do not have to accept Our Maximum Allowed Amount as full payment. They can charge or “balance bill” you for any amount of their bill which We do not pay. This “balance billing” cost is on top of, and does not count toward, your Cost Sharing obligation.

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

### Precertification

For certain outpatient services covered under this rider and for all Inpatient admissions, you or your Provider must get Precertification from Us. If Precertification is not requested or if it is denied, your Covered Services will be reduced or denied as explained below. See the Managed Care Features in the ”Getting Approval for Benefits” section of your HMO Booklet for information on Precertification requirements.

For Covered Services from Out-of-Network Providers if your Provider is participating with Us, the Provider is responsible for getting the Precertification. If your Provider is not Participating with Us, you are responsible for making sure that your Provider has obtained Precertification, or payment will be reduced or denied as explained below**.**

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

### Penalty for Not Obtaining Precertification

If Precertification for a Covered Service from a Non-participating Provider is not received in advance payment may be reduced:

* If there has been no Precertification for a Covered Service, but the Covered Service needed to be preauthorized and would have been covered, a penalty of 20 percent will be applied. If the services were not preauthorized and it is determined that they would not be covered then the services would be denied. This 20 percent penalty is based on the Maximum Allowed Amount for the Covered Service. This penalty amount is in addition to your Deductible and Coinsur- ance requirements. If your Out-of-Pocket Annual Maximum is reached, you are still responsible for the penalty amount.
* If Precertification 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.

# Benefits/Coverage (What is Covered)

You may receive benefits for Covered Services at the Out-of-Network benefit level under this rider if they are not provided by an In-Network Provider. Out-of-Network benefits are available under this rider for **all** Covered Services under the BlueAdvantage HMO Booklet, except those listed in the “Limitations/Exclusions (What is Not covered and Pre-Existing Conditions” section of this rider. In addition, all services are also subject to the “Limitations/Exclusions (What is Not covered and Pre-Existing Conditions” section of your BlueAdvantage HMO Booklet.

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 Precertification requirements described in *“*How to Access Your Services and Obtain Approval of Benefits” 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 *Schedule of Benefits.*

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

Some Covered Services have a maximum number of days, visits or dollar amounts that We will allow during a Benefit Period. 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 *Schedule of Benefits*.

# Limitations/Exclusions (What is Not Covered and Pre-Existing Conditions)

This section talks about the items that are not covered. The items here are not Covered Services under this rider. These exclusions are in addition to the “Limitations/Exclusions (What Is Not Covered)” of your BlueAdvantage HMO Booklet. However, the following services may be covered under your BlueAdvantage HMO Booklet.

The list of exclusions is not a complete list of all services, supplies, conditions or situations that are not Covered Services. Just because a service is not mentioned below does not mean it will be covered. It is important to know that in the “Benefits/Coverage (What Is Covered)” section and in other parts of the Booklet there are limits, conditions, and exclusions which apply, even if no mentioned below. The list below is meant as an aid to show common items which are not covered.

### We do not provide benefits for services, supplies, conditions, situations or charges under this rider for:

* Non-emergency Ambulance and transportation services.
* Infertility services.
* Human organ and tissue transplant services.
* Chiropractic therapy.
* Massage therapy.
* Acupuncture/nerve pathway therapy.
* Outpatient Prescription Drugs.
* Retail health clinics.
* Services requiring Precertification. If you choose to receive the services without obtaining Precertification for Non- participating Providers, and the services would have been covered, payment may be reduced. See Precertification in the “How to Access Your Services and Obtain Approval of Benefits” section of your Booklet for information on which services need Precertification for information on how to obtain authorization and the penalty amounts for not obtaining Precertification.
* Services received outside the state of Colorado are not covered except for Emergency Care and Urgent Care.

# Member Payment Responsibilities

Cost Sharing is how We share the cost of health care services with you. It means what We are responsible for paying and what you are responsible for paying. You meet your Cost Sharing requirements through your payment of Deductibles and Coinsurance under this rider (as described below). How much you have to pay depends on the choices you make of Providers. For example, if you choose to use a Participating Provider or Participating facility, your out-of-pocket costs may be less than if you choose a Non-Participating Provider or Non-Participating facility. Your Cost Sharing requirements are based on the Maximum Allowed Amount**.**

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

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 Participating 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 Booklet. Non-Participating Providers do not have that rule. They can charge or “balance bill” you for any amount of their bill which We do not pay. This “balance billing” cost can be large, and is on top of, and does not count toward, your Cost Sharing obligation.

# Maximum Allowed Amount

### General

This section describes how We determine what We pay for Covered Services. Reimbursement of Covered Services given to you by a Participating and Non-Participating Provider is based on your plan’s Maximum Allowed Amount for the Covered Service that you receive. Please see “Inter-Plan Arrangements” in the “Claims Procedure (How to File a Claim)” section for more information.

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

* that meet Our definition of Covered Services, to the extent such services and supplies are covered under this Booklet and are not excluded;
* that are Medically Necessary; and
* that are provided with all applicable Precertification, utilization management or other requirements in this Booklet.

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

Generally, services received outside the state of Colorado from an Out-of-Network Provider under this product are not covered except for Emergency Care or Urgent Care. When you receive Covered Services from an Out-of-Network Provider who is within the state of Colorado you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charge unless the Provider is practicing. 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 happens, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor or other Provider, We may reduce the Maximum Allowed Amounts for those secondary and later procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for parts 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 Participating or Non-Participating.

A Participating Provider is a Provider who is in the Provider network for this specific health benefits plan. 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 if you have not yet met your Deductible or have a Copayment or Coinsurance. Please call member services for help in finding a participating Provider or visit [www.anthem.com.](http://www.anthem.com/)

Providers who have not entered into a Participating Provider contract with Us are non-participating Providers and are not in any of Our networks subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary 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 at Our discretion, and which We may 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 (CMS) for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, We will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers’ fees and costs to deliver care; or
4. An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through Care Management; or
5. An amount based on or derived from the total charges billed by the non-participating Provider.

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

For Covered Services rendered outside the state of Colorado by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan’s non-participating provider fee schedule/rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of areas claims may be based on billed charges, the pricing We would use if the healthcare services has been obtained within Our Service Area, or a special negotiate price.

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 “balance billing” amount can be large. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call member services for help in finding a Participating Provider or visit Our website at [www.anthem.com.](http://www.anthem.com/)

Member services 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 get from your Provider the specific procedure code(s) and diagnosis code(s) for the services they will give you. You will also need to know the Provider’s charges to calculate your out of pocket responsibility. Although member services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For prescription drugs, the maximum allowed amount is the amount determined by us using prescription drug cost information provided by the pharmacy benefits manager.

### Claims Review

We have processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. When you seek services from Out-of-Network Providers you could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also

be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

### Member Cost Share

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 plan, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount. For example you would need to pay for your Deductible and/or Coinsurance.

Your cost share amount and out-of-pocket limits may vary depending on whether you receive services from a Participating Provider or Non-Participating Provider. This means you may be required to pay higher cost share amounts or may have limits on your benefits when using Non-Participating Providers. Please see the *Schedule of Benefits under the heading of* “Out-of-Network” for your cost share amounts and limitations. You can also call member services to find out your health benefit coverage or cost share amounts which can vary by the type of Provider you use.

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

Sometimes you may only be asked to pay the lower Participating Provider Cost Sharing amount when you use a Non- Participating Provider. For example, if you go to a Participating Hospital or Provider Facility you may receive Covered Services from a Non-Participating Provider like a radiologist, anesthesiologist or pathologist. If you did not know that the Provider is not Participating, and that Provider is employed by or contracted with a Participating Hospital or facility, you will not have to pay more for the Covered Services than you would have had to pay if it had been received from a Participating Provider.

Under certain events, if We pay the Provider amounts that are your responsibility, such as Deductibles and/or Coinsurance, We may get those amounts back from you. You agree that We have the right to collect such amounts from you.

### Deductible

A Deductible is a set dollar amount for Covered Services that you must pay within your Benefit Period before We pay for Covered Services. Deductibles do contribute toward your Out-of-Pocket Annual Maximum. The Deductible amount is listed in the *Schedule of Benefits*.

Each Member must meet a separate Deductible. A new Deductible is required for each Benefit Period. The Deductible requirements must be met before you begin paying Coinsurance for benefits under this rider.

**Family Deductible -** The family Deductible is a combined Deductible. This means any combination of amounts paid by family Members toward Covered Services can be used to satisfy the family Deductible. One person may not contribute more than the individual Deductible toward the family Deductible.

The family Deductible applies to newborn and adopted children for the first 31-day period following birth or adoption if the child is enrolled or not enrolled following the 31-day period.

### Coinsurance /Out-of-Pocket Annual Maximum

You must first meet your annual Deductible if applicable. After the Deductible is met you pay a percentage of charges for Covered Services as listed on the *Schedule of Benefits*. This percentage is called Coinsurance.

The Out-of-Pocket Annual Maximum is designed to protect you from catastrophic health care costs. Once you and/or your family have satisfied the Out-of-Pocket Annual Maximum, no additional Deductible or Coinsurance will be required for you and/or your family for the remainder of the Benefit Period. The Out-of-Pocket Annual maximum is found on the *Schedule of Benefits*. The Out-of-Pocket Annual Maximum does include Deductible amounts. The Out-of-Pocket Annual Maximum does include penalties for not obtaining Precertification, expenses in excess of the Maximum Allowed Amount, or expenses for non-covered services.

You pay the Coinsurance percentage for Covered Services until the Out-of-Pocket Annual Maximum is reached for your Benefit Period. Once the Out-of-Pocket Annual Maximum is reached, We pay 100 percent of any remaining eligible charges for the rest of your Benefit Period. You will always be responsible for the difference between Billed Charges and the Maximum Allowed Amount for Non-Participating Providers, even after reaching the Out-of-Pocket Annual Maximum for Out-

of-Network services. The difference between Billed Charges and the Maximum Allowed Amount for Non-Participating Providers does not apply towards your Out-of-Pocket Annual Maximum.

**Family Out-of-Pocket Annual Maximum** - The family Out-of-Pocket Annual Maximum is a combined Out-of-Pocket Annual Maximum. This means any combination of amounts paid by family Members toward Covered Services can be used to satisfy the family Out-of-Pocket Annual Maximum. One person may not contribute more than the individual Out-of-Pocket Annual Maximum toward the family Out-of-Pocket Annual Maximum.

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

### Benefit Period Maximum

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

If you leave this plan, and go on to a new plan with Us in the same Benefit Period, all covered benefits that have a Benefit Period maximum or lifetime maximum will be carried over to the new plan. For instance, if a benefit has a limit of one visit per Benefit Period and you received that benefit under the prior coverage, then you are not eligible under the new plan for the same benefit until the Benefit Period ends, as benefits have been exhausted for your Benefit Period.

# Claims Procedure (How to File a Claim)

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

When a Participating Provider bills Us for Covered Services, We will pay the charges for the benefit directly to the Provider. You are responsible for giving the Participating Provider all the information needed for them to submit a claim. You pay a Deductible and/or Coinsurance to the Provider when you get a Covered Service.

We or our designee administers claims under this Rider. If a Non-Participating Provider does not bill Us directly, you must file the claim. To get claim forms, call Our member services or print it from Our website at [www.anthem.com.](http://www.anthem.com/) If We do not give you a claim form within 15 days of your request, you may submit written proof of the claim and will be considered to have complied with the rules of this Booklet for submitting a claim. You must complete the claim form and attach the itemized bill from the Provider. Balance due statements, cash register receipts and cancelled checks are not accepted. All information on the claim form and itemized bill must be readable. To find out the dollar amount, use the exchange rate as it was on the date you received care. If information is missing on the claim form or is not readable, the form will be returned to you. The information contained on the itemized bills will be used to determine benefits, so it must support information reported on the submitted claim form. The claim form has detailed instructions on how to complete the form and what information is needed.

A separate claim form is required for each Non-Participating Provider for which you are requesting payment.

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

### How and Where to Send Claims

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

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

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

HMO Colorado Claims

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

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

### 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 noncovered services. Payments for Covered Services received from a Non-Participating Provider are made to you. You are responsible for paying the Non-Participating Provider, including any amounts greater than Our Maximum Allowed Amount.

# Definitions

This section defines words and terms used in this rider that are either not defined in the Glossary of your BlueAdvantage HMO Booklet or are used in a different way in your BlueAdvantage HMO Booklet. The first letter of each of these words will be capitalized when used in this Booklet. Please see the Glossary of your BlueAdvantage HMO Booklet for additional definitions. You should refer to this section and your HMO Booklet to find out exactly how a word or term is used for the purposes of this rider.

**Coinsurance** — percentage of costs you share with Us after you meet the Deductible.

**Deductible** — is the dollar amount of Covered Services, listed in the *Schedule of Benefits*, which you must pay before benefits begin under this Booklet.

**In-Network** — a term describing Providers that enter into a HMO network contract with Us for this specific health plan.

**Maximum Allowed Amount -** The maximum amount that We will allow for Covered Services that you receive. More details can be found in the “Member Payment Responsibilities” section of this rider.

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

* + A Facility Provider, such as a Hospital, that has not entered into a Participating Provider contract with Us;
  + A Professional Provider, such as a Doctor, who has not entered in to a Participating 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 Participating or Non-Participating Providers that have not entered into a network contract with Us. Services received from a participating or Non-Participating Provider, usually result in a higher out-of-pocket costs to you than services you get from a HMO Colorado In-Network Provider.

**Out-of-Pocket Annual Maximum**— the Cost Sharing total that you may be responsible for under this rider for most medical costs. Benefit Period maximums or lifetime maximums under this Booklet 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.

# TITLE PAGE (COVER PAGE)

**HMO Colorado**

Name of Carrier **BlueAdvantage HMO Plan 10-200** Name of Plan

# on Essential Formulary

# CONTACT US

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 costs, including most costs for Doctor and outpatient care, Emergency care and Hospital inpatient care. Throughout this Booklet, “Our”, “We” and “Us” refer to HMO Colorado.

This Booklet is a guide to your coverage. Please review this document to become familiar with your benefits, including what is not covered. By learning how coverage works, you can help make the best use of your benefits.

For questions about coverage, please visit Our website or call Our Member Services department. The website address is [www.anthem.com](http://www.anthem.com/) and the toll-free Member Services number is located on the *Summary of Benefits* section found in this Booklet or the Health Benefit ID card mailed to your home.

**Identity Protection Services** - Identity protection services are available with Our Anthem health plans. To learn more about these services, please visit [www.anthem.com/resources**.**](http://www.anthem.com/resources)

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



Mike Ramseier

President and General Manager HMO Colorado

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

Health benefit coverage is defined in the following documents:

* This Booklet, the *Summary of Benefits* and any amendments to it.
* The application and any other application from you or your Dependents.
* Your Health Benefit ID Card.

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

* The employer master application.
* The Employer Master Contract between Us and your employer.

We, or someone on Our behalf, will determine how benefits will be managed and who is eligible under this Booklet. If any question comes up about any terms of this Booklet, or how they are applied, Our determination will be final. This may include questions of whether the services, care, treatment, or supplies are Medically Necessary, Experimental or Investigational, or Cosmetic. But you may use all applicable “Appeals and Complaints” procedures found in a section in this Booklet.

This Booklet is not a Medicare Supplement plan. If you are eligible for Medicare, please review the Medicare Supplement Buyer’s Guide available from Our Member Services.

# Member Rights and Responsibilities

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

### You have the right to:

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

### You have the responsibility to:

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

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

We want to provide high quality benefits and member service to Our Members. Benefits and coverage for services given under the plan are governed by the Booklet and not by this Member Rights and Responsibilities statement.

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

### How to Obtain Language Assistance

We are committed to communicating with Our Members about their health plan, no matter what their language. We use a language line interpretation service. Simply call the Member Services phone number on the back of your Health Benefit ID Card and a person will be able to assist you. Translation of written materials about your benefits can also be requested by calling Member Services.

# 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 Care SM benefit is designed to bring you peace of mind if you are on vacation, have a dependent attending school in another state or have family members living in a different Service Area outside of Colorado.

### 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 Us within seventy-two hours of treatment or admission or as soon as reasonably possible.
* For non-Emergency care, call your PCP or Us for Precertification. The Precertification phone number is on the back of your Health Benefit ID Card.

### Extended Stays

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

* Call Guest Membership toll free at 1-800-827-6422 for eligibility and specific location information. Guest Membership is not available in all areas.
* If a participating HMO (Host 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 PCP (in some cases, you may be asked to choose a PCP), and information on how to use your Guest Membership.
* The Host HMO does not cover dental, vision, chiropractic care, massage therapy, acupuncture, nutritional counseling and substance abuse rehabilitation.
* Use your 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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# ELIGIBILITY

# Subscriber

The Subscriber is a Member in whose name the plan is issued.

If you are a new employee who works or resides in the Service area and you have a normal work week as noted in the Employer Master Contract, you can join the plan as a Subscriber. You can ask the employer for the number of hours you must work and other rules to be enrolled.

Your Dependents may include the following:

# Dependents

* **Legal spouse,** the Subscriber’s spouse, including the partner to a civil union as recognized by Law. For information on spousal eligibility please contact the Group.
* **Common-law spouse**, all references to spouse in this Booklet include a common-law spouse.

A common law spouse is an eligible Dependent who has a valid common-law marriage. This is the same as any other marriage and can only end by death or divorce.

* **Designated beneficiary**. Your employer may have decided to offer benefits under this plan to designated beneficiaries. Check with your employer to learn more. If they are recognized by the employer, all references to spouse in this Booklet include a designated beneficiary. A Recorded Designated Beneficiary Agreement will need to be provided. A designated beneficiary is not eligible for COBRA under this Booklet.

A designated beneficiary is an agreement entered into by two people for the purpose of making each a beneficiary of the other and which has been recorded with the county clerk and recorder in the county in which one of the person lives. The agreement is based on the Colorado Designated Beneficiary Act.

* **Same-sex (and, subject to Our Underwriting approval, opposite-sex) domestic partner**. Check with your employer to see if a domestic partner will be eligible. If domestic partners are recognized by the employer, all references to spouse in this Booklet include a domestic partner.

Domestic partner means a person of the same sex (or opposite sex if approved by Underwriting) is the Subscriber’s sole domestic partner; he or she is mentally competent; he or she is not related to the Subscriber by blood closer than permitted by applicable law for marriage; he or she is not married to anyone else; and he or she is financially interdependent with the Subscriber.

* **Newborn child**. A newborn child born to you or your spouse is covered under your coverage for the first 31 days of birth. If the newborn is your grandchild, the newborn is usually **not** covered (see the “Grandchild” heading in this section).

During the first 31 days after birth, a newborn child will be covered for Medically Necessary care. This includes well child care and treatment of medically diagnosed Congenital Defects and Birth Abnormalities. This is regardless of the limitations and exclusions applicable to other conditions or procedures of this Booklet. All services during the first 31 days are subject to Cost Sharing and any benefit maximums that apply to other conditions.

To keep the child’s coverage beyond the 31-day period, please send Us an “Required application” to add the child if you have a non-family plan. We must get this form within 31 days after the birth of the child to continue coverage. You do not need to complete the form to add the child if you had family coverage at the time of birth of the child and if no additional Premium is required. Just provide Us notice within 60 days of the child’s birth.

* **Adopted child**. An unmarried child (who has not reached 18 years of age) adopted while you or your spouse is enrolled will be covered for 31 days after the date of placement for adoption.

“Placement for adoption” means when a Subscriber has a legal obligation to partially or totally support a child in anticipation of the child’s adoption. A placement ends when the legal obligation for support ends.

To keep the adopted child’s coverage beyond the 31-day, you must send Us an “Required application” to add the adopted child. We must get this 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 Booklet. Coverage stops at the end of the month in which the child turns 26. If you or your spouse have a

qualified medical child support order for this child, the Dependent child is eligible for coverage, up to age 26, whether the child lives with you or your spouse.

* **Disabled Dependent child**. Eligibility will be continued past the age limit only for those Dependents who are unmarried and medically certified as disabled and are dependent upon the parent Subscriber. We may ask for a physician to certify the Dependent’s eligibility. We must be informed of the Dependent’s eligibility for continuation of coverage within 30 days after the date Dependent would normally become ineligible. You must notify Us if the Dependent’s tax exemption status changes and if he or she is no longer eligible for continued coverage.
* **Grandchild**. A grandchild of yours or your spouse is not eligible for coverage unless you or your spouse are the court- appointed permanent guardians or have adopted the grandchild. You must send an “Required application” and proof of the court appointment or the legal adoption. One other option is to enroll the grandchild under an individual child-only plan with, subject to its terms and conditions.

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

# Medicare-Eligible Members

Before you turn 65, or if you qualify for Medicare in other ways, you should contact the local Social Security Administration office to establish Medicare eligibility. You should then contact the employer to talk about options.

For details on how the benefits will be coordinated between Medicare and this plan, see the “General Plan Provisions” section.

# Enrollment Process

This section lists who is eligible and what forms are needed for enrollment. Coverage starts on the Effective Date in Our files. No services before that date are covered.

Note: Sending an “Required application” does not guarantee you get on the plan.

### Enrollment Forms

You must send Us an “Required application” to add any Dependents. More forms may be needed for special Dependent status. You can get such forms from your employer, Our Member Services or Our website.

### Initial Enrollment

We must receive the enrollment form within 31 days after the date of hire or within 31 days of when the waiting period ends. The Effective Date will be determined by the waiting period. The employer can tell you the length of the waiting period.

### Open Enrollment

Any eligible employee who did not enroll when they were first eligible can enroll during the employer’s annual open enrollment period. This period is generally 31 days before the employer’s Anniversary Date. The annual open enrollment period is subject to all provisions of the Booklet. The employer can tell you more about the open enrollment period.

### Newly Eligible Dependent Enrollment

You 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. To add the Dependent, We must get an “Required application” within 31, but no more than 60, days of the date of the event. Proof of the event, e.g., a copy of the marriage certificate or court order, must be attached to the form.

When you or your spouse are required by a court or administrative order to cover 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 application. If you do not add the eligible Dependent within 31 days of the issuance of the order, you must wait until the next open enrollment to add the Dependent.

### Special Enrollment Periods

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

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

Special enrollment is available for eligible individuals who:

* Lost coverage due to death of a covered employee.
* Due to termination or reduction in number of hours of the employee’s employment.
* The covered employee becomes ineligible for benefits under Title XVIII of the Federal Social Security Act, as amended.
* Lost coverage under a health benefit plan due to the divorce or legal separation of the covered employee’ spouse or partner in civil union.
* Is now eligible for coverage due to marriage (including a civil union where recognized in the state where the Subscriber resides), birth, adoption, placement for adoption, placement in foster care.
* By entering into a Designated Beneficiary Agreement, if covered by the employer, or pursuant to a QMCSO or other court or administrative order mandating that the individual be covered.
* Termination of employment or eligibility for coverage, regardless of eligibility for COBRA or state continuation.
* Has a reduction in the number of hours of employment.
* Due to involuntary termination of coverage.
* Has a reduction or elimination of group contributions toward the cost of the prior health plan.
* Lost eligibility under the Colorado Medical Assistance.
* When the employee or dependent becomes eligible for premium assistance under the Colorado Medical Assistance Act of the Children’s’ Basic Health Plan.
* A parent or legal guardian disenrolls a dependent, or a dependent becomes ineligible for the Children’s Basic health Plan.

### Important Notes about Special Enrollment:

* You must request coverage within 31 days of a qualifying event (i.e., marriage, birth of child etc.). For loss of coverage under the Colorado Medical Assistance Act, coverage must be requested within 60 days of the loss of coverage. For loss of coverage under the Children’s Basic Health plan coverage must be requested within 90 days of the loss of coverage.
* Evidence of prior Creditable Coverage is required and must be furnished by you or your prior carrier.

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

**Loss 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 you or your Dependents. You must file an application with the employer within 60 days after coverage has ended. Also, 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. This includes any waiver or demonstration project conducted under or in relation to these plans. Similarly, you must file an application with the employer within 60 days after the eligibility date for assistance is determined.

### Late Entrants

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

### Military Service

Employees going into or coming back from military service can keep this coverage. This choice is required by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights apply only to employees and their Dependents covered under the plan before the employee leaves for military service:

* The longest period of coverage under this paragraph is the lesser of.
  + 24 months, starting on the date when the absence starts; or
  + The day after the person was required to, but failed to, apply for or return to work.
* A person who opts to keep this coverage may be asked to pay up to 102% of the Premium. But those on active duty for 30 days or less cannot be asked to pay more than the employee’s share, if any, for the coverage.

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

### Multiple Coverage Plans with Us

You may have more than one group health plan with Us or any of Our affiliates. If you don’t want both plans, you can cancel one of the plans and ask for a Premium refund. But to get a refund, you must tell Us within 31 days after the dual coverage starts. If We do not get notice within 31 days, you will not get a refund of past Premium. But you can still ask Us to cancel the plan you no longer want.

# How to Change Coverage

If a group provides you with multiple health care options, you may switch to another coverage offered by the group during open enrollment.

# HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

This is a Health Maintenance Organization (HMO) plan. We have coordinated and contracted with a network of Doctors, Hospitals, and support services (e.g., laboratory, x-ray, pharmacy, and physical therapy) to arrange for or provide total health care services to Members. Learning how an HMO works can help you make the best use of your health care benefits. The *Schedule of Benefits* lists out-of-pocket expenses and certain benefit limits you may incur. We strive to keep health care costs reasonable by working with you, your Doctor, Hospitals, and other Providers in unity. You and your Primary Care Provider (PCP) work together to obtain care from a Specialist and to obtain Precertification for services. This helps to ensure that you receive care that is Medically Necessary, performed in the right setting, and is otherwise a Covered Service. If you need details about a Provider’s license or training, or help choosing a Doctor who is right for you, call the member service number on the back of your Health Benefit ID card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

### Please note that care must be received from your Primary Care Physician (PCP) or another In-Network Provider to be a Covered Service. If you use an Out-of-Network Provider, your entire claim will be denied unless:

* **The services are for Emergency or Urgent Care.**
* **The services are approved in advance by HMO Colorado as an Authorized Service.**

# Primary Care Provider (PCP)

A key feature of an HMO is that one Provider will be primarily responsible for delivering and coordinating all of your care. That Provider is called a Primary Care Provider (PCP). PCPs are typically internal medicine Doctors, family practice Doctors, general practitioners, pediatricians, advanced nurse practitioner or advanced registered nurse practitioners. As your first point of contact, the PCP gives 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 for In-Network Providers without a referral. As well, no authorization or referral is needed for an OB/GYN and certified nurse midwife care. Your PCP can provide you referrals and information about Specialists who are In-Network.

If We do not have an In-Network Provider for a Covered Service, We will arrange for an authorization to a Provider with the necessary expertise. We will also make sure 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 In-Network Provider.

Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service, even if Medically Necessary, performed by your PCP, or another In-Network Provider. If a service requires Precertification before it can be performed, your In-Network Provider is responsible for getting the Precertification. See “Getting Approval of Benefits” below for information.

### Selecting A PCP

When you enroll, you must select a PCP. Family members are not required to choose the same PCP; they may select a PCP individually. For a covered child, you may also choose a pediatrician as the child’s PCP. If a PCP is not chosen, We will assign one to you.

To locate a PCP go to Our directory of HMO Providers. Please note that We have several networks, and that a Provider that is In-Network for one plan may not be In-Network for another. Be sure to check your Health Benefit ID Card or call member services to find out which network this plan uses. The directory lists Doctors and Hospitals that are affiliated with each PCP. You can get a directory from your employer or from Us. You may also search for a Provider on-line at [www.anthem.com](http://www.anthem.com/) You may call the member service number that is listed on your Health Benefit ID Card or you may write Us and ask Us to send you a directory. Our listings include the credentials of Our physicians such as specialty designation and board certification.

Our website is continuously updated and is the most up-to-date list of Our PCPs. Some Doctors 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 make sure that the Provider is still accepting new patients (unless you are already an existing patient of the PCP).

When you visit an In-Network Provider an In-Network Provider will bill Us directly and accept Our Maximum Allowable Amount as payment in full. The Maximum Allowable Amount is the dollar amount approved by Us for a specific covered service.

### 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.

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 see how far in advance you must tell them of a cancellation. You may be charged a fee by your PCP’s office for a missed appointment. We will not pay for such a fee. You should notify the PCP’s office if you are going to be late for an appointment. The PCP may ask you to reschedule the appointment.

After hours care is provided by your Provider who may have a variety of ways of doing this. 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. More information program can be found on the page entitled Care Outside of Colorado located in the front of this Booklet.

### Changing PCPs

You may select a new PCP at any time (but no more than once per month) by requesting the change on the application. You can also do this by visiting Our website or by calling Our member 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 sent from one PCP to another, you must contact your prior 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. That new PCP needs to be within Our Service Area. You must notify Us within 31 days after a change in residence or place of employment by submitting the application.

### Care Outside of Colorado

When you are outside Our Service Area for extended periods of time, care is available through Guest Membership benefit. Details on the away from home care programs can be found in the front of this Booklet under Care Outside of Colorado.

# Voluntary Clinical Quality Programs

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

# Voluntary Wellness Incentive Programs

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

# Program Incentives

We may offer incentives from time to time at our discretion in order to introduce you to covered programs and services available under this Plan. The purpose of these incentives include, but is not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as Anthem offers the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, We recommend that you consult your tax advisor.

# The BlueCard Program

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

# Getting Approval for Benefits

We include the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigational as those terms are defined in this Booklet. Utilization Review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting/place of care.

Certain Services must be reviewed to determine Medical Necessity in order for you to get benefits. Utilization Review criteria will be based on many sources including medical plan and clinical guidelines. We may decide that a service that was asked for is not Medically Necessary if you have not tried other treatments that are more cost effective.

If you have any questions about the information in this section, you may call the member service phone number on the back of your Health Benefit ID Card.

### Coverage for or payment of the service or treatment reviewed is not guaranteed even if We decide your services are Medically Necessary. For benefits to be covered, We may consider on the date you get service:

1. You must be eligible for benefits;
2. Premium must be paid for the time period that services are given;
3. The service or supply must be the same as was precertified;
4. The service or supply must be for the same condition and setting that was precertified; and
5. You must not have exceeded any applicable limits under your coverage.

**Types of Reviews**

* **Pre-service Review** – A review of a service, treatment or admission for a coverage determination which is done before the service or treatment begins or admission date.
* **Precertification –** A required Pre-service Review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigational as those terms are defined in this Booklet.

For emergency services, Precertification is not required. For admissions following Emergency Care, you, your authorized representative or Doctor must tell us within 72 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not needed unless the admission lasts beyond the first 48 hours for a vaginal delivery or 96 hours for a cesarean delivery, or if the baby is not sent home at the same time as the mother.

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

Both Pre-Service and Continued Stay/Concurrent Reviews may be considered on an urgent or expedited timeframe when, in the view of the treating Provider or any Doctor with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment, or if you have a physical or mental disability, would create an imminent and substantial limitation on your existing ability to live independently. Urgent reviews are conducted under a shorter timeframe than standard reviews.

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

## Who is Responsible for Precertification?

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

|  |  |  |
| --- | --- | --- |
| **Provider Network Status** | **Responsibility to Get Precertification** | **Comments** |
| In Network | Provider | * The Colorado Provider must get Precertification when required |
| Out of Network/ Non-Participating | Member | Member has no benefit coverage for an Out-of-Network Provider unless:   * The Member gets approval to use an Out-of-Network Provider before the service is given, or. * The Member requires an Emergency Care admission (See note below.)   If these are true, then   * The Member must get Precertification when required. (Call Member Services.) For an Emergency Care admission, precertification is not required. However, you, your authorized representative, or Doctor must tell us within 72 hours of the admission or as soon as possible within a reasonable period of time. * Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary, not Emergency Care, or any charges in excess of the Maximum Allowed Amount. |
| Blue Card Provider | Member  **(Except for Inpatient Admissions)** | Member has no benefit coverage for a BlueCard Provider unless:   * The Member gets approval to use a BlueCard Provider before the service is given, or. * The Member requires an Emergency Care admission (See note below.)   If these are true, then |

|  |  |  |
| --- | --- | --- |
| **Provider Network Status** | **Responsibility to Get Precertification** | **Comments** |
|  |  | * The Member must get Precertification when required. (Call Member Services.) For an Emergency Care admission, Precertification is not required. However, you, your authorized representative, or Doctor must tell us within 72 hours of the admission or as soon as possible within a reasonable period of time. * Member may be financially responsible for charges/costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary, not an Emergency, or any charges in excess of the Maximum Allowed Amount. * **Blue Card Providers must obtain Precertification for all Inpatient Admissions.** |
| **NOTE: For an Emergency Care admission, Precertification is not required. However, you, your authorized representative or Doctor must tell Us within 72 hours of the admission or as soon as possible within a reasonable period of time.** | | |

## How Decisions are Made

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

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

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

## Decision and Notice Requirements

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

|  |  |
| --- | --- |
| **Type of Review** | **Timeframe Requirement for Decision and Notification** |
| Expedited Pre-service Review | 72 hours from the receipt of request |
| Non-expedited Pre-service Review | 15 calendar days from the receipt of the request |
| Expedited Concurrent/Continued Stay Review when request is received more than  24 hours before the end of the previous authorization | 24 hours from the receipt of the request |
| Expedited Concurrent/Continued Stay Review when request is received less than  24 hours before the end of the previous authorization or no previous authorization exists | 72 hours from the receipt of the request |
| Non-expedited Concurrent/Continued Stay Review for ongoing outpatient treatment | 15 calendar days from the receipt of the request |
| Post-Service Review | 30 calendar days from the receipt of the request |

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

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

## Important Information

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

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

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

You may find out whether a Provider is taking part in certain programs by checking your on-line Provider Directory, on-line pre-certification list or contacting the Member Services number on the back of your Health Benefit ID Card.

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

## Health Plan Individual Case Management

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

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

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

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

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of you and Us and you or your authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your authorized representative in writing.

# BENEFITS/COVERAGE (What is Covered)

This section describes your benefits. To get benefits for Covered Services, you must use In-Network Providers, unless We have an approved in advance as an Authorized Service or if your care involves an Emergency or Urgent Care situation If you use an out-of-network Provider your services may be denied if services are not for an exception as indicated above. To learn more, read your *Summary of Benefits*.

Covered Services and supplies are only covered if they are Medically Necessary or preventive. They are not covered if they are Experimental or Investigational, and/or Cosmetic. They are not covered if not precertified where required. All services must be standard medical practice where they are received for the health problem being treated, and they must be legal in the United States. The fact that a Provider may order, advise or approve that you receive a service, treatment or supply does not make it Medically Necessary or a Covered Service. It also does not promise payment by Us. To learn more, read the “How to Access Your Services and Obtain Approval of Benefits” section in this Booklet.

Services, supplies, tests and drugs are not covered if they are excluded under this Booklet or are not obtained in the way required by this Booklet. To learn more, read the exclusions in each covered benefit, the limits in the *Summary of Benefits*, and the “Limitations/Exclusions (What Is Not Covered)” section of this Booklet.

# Preventive Care Services

Preventive Care Services include screenings and other services for adults and children with no current symptoms or history of a health problem. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when you use a participating Provider. Those laws, and your coverage, may change from time to time.

Preventive care does not include services when you have symptoms or have been diagnosed with a medical problem. Instead, those services will be considered for possible coverage under the Doctor Office Services or Diagnostic Services benefits below if the Covered Services does not fall within the state or ACA-recommended preventive services.

Covered Services fall under the following broad groups as shown below:

* Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples are:
* Breast cancer.
* Cervical cancer.
* Colorectal cancer.
* High blood pressure.
* Type 2 diabetes Mellitus.
* Cholesterol.
* Child and adult obesity.
* Routine shots, including flu shots, for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
* Preventive care and screenings for children, adolescents, and adults are based on the comprehensive guidelines from the Health Resources and Services Administration. This includes child health supervision services.
* Other preventive care and screening for women are also covered based on the guidelines from by the Health Resources and Services Administration, including the following:
* Women’s contraceptives, sterilization procedures, and counseling. This includes Generic and single source brand Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants are also covered. At least one product in all 18 approved methods of contraception is covered under this plan without cost sharing as required by federal and applicable law. Multi-Source Drugs will be covered as a Preventive Care benefit when Medically Necessary, according to your attending Provider, otherwise they will be covered under the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section.
* Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
* Gestational diabetes screening.
* Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
  + Counseling.
  + Prescription Drugs.
  + Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

Prescription Drugs and OTC items are limited to a no more than 180 day supply per 365 days.

* Prescription Drugs and OTC items identified as an “A” or “B” recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:
  + Aspirin.
  + Folic acid supplement.
  + Vitamin D supplement.
  + Bowel preparations.

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

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

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

[http://www.healthcare.gov/what-are-my-preventive-care-benefits.](http://www.healthcare.gov/what-are-my-preventive-care-benefits) [http://www.ahrq.gov/.](http://www.ahrq.gov/)

<http://www.cdc.gov/vaccines/acip/index>

### As required by applicable law, preventive care services also include:

* Routine screening mammogram.
* Routine cytologic screening (Pap test).
* Routine prostate specific antigen (PSA) blood test and digital rectal examination.
* Colorectal cancer examination, including 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.
* Cervical cancer vaccinations for females.

### In addition to federal and applicable law rules, the following preventive care services are covered:

* Annual medical diabetes eye exams, or as often as your Provider decides.
* Flu shot from a flu shot clinic. Coverage is provided for one flu shot per Benefit Period, or more often as We decide. Some places that may give flu shots are your local pharmacy, at your job, or a grocery store. There may be other flu shot clinic locations not listed. To learn more about how much We pay you back for a flu shot, and to get the claim form, visit Our website at [www.anthem.com.](http://www.anthem.com/) You may also call Our Member Services. The amount We cover is subject to change. A flu shot paid for in full, or in part by someone else, is not eligible for coverage.

# Infertility Diagnostic Services

We cover tests, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis, and services to find the cause of infertility. We do not cover the treatment of infertility.

Coverage for the diagnosis of infertility includes inpatient services, outpatient services, and Doctor office services.

# Maternity Services and Newborn Care

Coverage for maternity and newborn care covers inpatient services, outpatient services and Doctor office services for normal pregnancy. This includes one routine ultrasound and normal routine nursery care for a well newborn baby. We also cover complications of pregnancy, as needed by applicable law, and miscarriage. The newborn baby is covered for Medically Necessary care and treatment of injury and sickness, and medically diagnosed Congenital Defects and Birth Abnormalities.

After childbirth, We will cover the mother and the baby for at least 48 hours in a Hospital. If delivery is by cesarean section, coverage will be for at least 96 hours. If the baby is born between 8:00 p.m. and 8:00 a.m., coverage will continue until 8:00

a.m. on the morning after the 48 or 96 hours timeframe. But the mother and baby can leave sooner if the mother and Doctor or certified nurse midwife agree to do so.

At-home visits following child-birth are covered for you at your home by a Doctor, nurse or certified nurse midwife. This needs to be done within seventy-two (72) hours after you and your baby are released from the Hospital. Coverage for this visit includes, but is not limited to:

* Parent training.
* Physical assessments.
* Assessment of the home support system.
* Help and training in breast or bottle feeding.
* Performance of any maternal or neonatal tests routinely performed during the usual course of inpatient care for the mother or newborn child, including collecting samples for hereditary disease and metabolic newborn screening.

The mother can decide that this visit may happen at the Doctor’s office.

We pay for Covered Services from a Provider for therapeutic or elective termination of pregnancy regardless if Medically Necessary, unless applicable law or regulation prohibits the employer from providing such coverage (in which case, Covered Services are provided only to the extent necessary to prevent the death of the mother or unborn baby).

# Diabetes Management Services

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

Screenings for gestational diabetes are covered under Preventive Care Services.

# Doctor Office Services

We cover Doctor office visits when needed to check your health, or to discuss and find the cause of a health problem, or to get treatment and non-urgent and non-Emergency medical care. Services include getting second opinions on a condition, or discussing birth control or family planning. For allergies, We also cover Doctor office visits to get testing, shots and serum.

See this “Benefits/Coverage (What is Covered)” section for more information on Prescription Drugs administered in the office.

Some things like x-rays or lab tests or surgical services will not always be covered as an office visit, even if done in a Doctor’s office. Those services may be subject to additional Copayment or benefit restrictions. Also, there may be a limit on how many times you can visit a Doctor or Provider for certain treatments. Some examples are physical/speech therapy, or chiropractic therapy. To learn more, see the *Summary of Benefits*.

When available in your area, your coverage will include online visit services. Covered Services include a medical session using the web by webcam, chat or voice. For Mental Health and Substance Abuse online visits see “Mental Health and Substance Abuse Services”.

# Telehealth Services

Covered Services that are appropriately provided by a telehealth Provider in accordance with applicable legal requirements will be eligible for benefits under this Booklet. Telehealth means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and mental health. Telehealth is two-way audio-visual communication, including synchronous interactions and store-and-forward transfers. In-person contact between a health care Provider and the patient is not required for these services.

Telehealth does not include the use of facsimile, audio-only telephone, texting or electronic mail. If you have any questions about this coverage, or receive a bill please contact member service at the number on the back of your Health Benefit ID Card.

# Inpatient Services

Inpatient Hospital Services are for acute care in a Hospital. Benefits are for charges from a Hospital for room, board and general nursing services, ancillary (related) services, and services from a Doctor while you are in the Hospital. An inpatient admission may include physical, occupational and speech therapy services care as part of your acute admission. If an inpatient admission is only for the purpose of rehab see the next section for Inpatient Rehab Services since that care is limited.

### Room, Board and General Nursing Services

* A room with two or more beds.
* A private room but only if it is Medically Necessary that you occupy a private room. For example a private room may be needed for isolation. If it is Medically Necessary for you to be in Hospital, but not in a private room, We will only allow benefits for the Hospital’s average rate for a semi-private room.
* A room in a special care unit approved by Us. The special care unit must be set up to give intensive care and support to critically ill patients.

### Ancillary Services

* Operating, delivery and treatment rooms and supplies.
* Prescribed drugs given as part of the inpatient stay.
* Medical and surgical dressings, supplies, casts and splints.
* Diagnostic services.
* Therapy services;
* General nursing care.
* Charges for processing, transportation, handling and giving of blood. Charges for blood, blood plasma and blood products are covered unless the blood, blood plasma or blood products were given to you from a blood bank.

### Other Services

* Medical care visits limited to one visit per day by any one professional Provider.
* Intensive medical care when your health problem requires it for a long time.
* If you are in the Hospital for Surgery, and your condition requires it, care by two or more Doctors during one Hospital stay may be covered.
* Being seen by another professional Provider when your professional Provider asks. But if the request is made just because of Hospital rules, coverage is not available.
* Surgery Services, including Reconstructive Surgery.
* Anesthesia, Anesthesia supplies and services.
* Newborn examinations by a Doctor other than the Doctor who performed the obstetrical delivery.

### Copayment Waiver

When you move from one Hospital to another Hospital on the same day, any Copayment stated in dollars per admission in the *Summary of Benefits* is not applied for the second admission. Copayments stated as a percentage or per day are not waived.

# Inpatient Rehab Services

If We determine that you no longer need acute Hospital care, or that the main reason for a Hospital stay is to restore or improve functions you have lost because of an injury or illness, We will consider the care to be Inpatient Rehab Therapy. We cover Inpatient Rehab Therapy up to the maximum number of days listed on the *Summary of Benefits*.

Benefits for inpatient care are available while you are at a rehab Facility for the **main reason** of getting rehab services. For example, if your care includes at least three hours of therapy, We may consider it Inpatient Rehab Therapy. Some therapies are speech therapy, respiratory therapy, occupational therapy and/or physical therapy. There may be differing levels of therapy, like Acute Rehab Therapy, Chronic Rehab Therapy or Sub-Acute Rehab Therapy. But to be eligible for benefits, rehab services must be aimed at goals that can likely be met in a reasonable period of time. Benefits are not available for Custodial Care. Benefits will end at the earlier of:

* When rehab is no longer Medically Necessary and you stop meeting those goals.
* When you have used up the day limit as listed on your *Summary of Benefits*.
* We decide that Maximum Medical Improvement is reached and no further major changes can be made.

### Skilled Nursing Facility (SNF)

A Skilled Nursing Facility is a place that gives you skilled nursing care. Benefits are for charges from a Skilled Nursing Facility for room, board and general nursing services, ancillary (related) services, and services from a Doctor while you are in the Facility. For example it gives you therapies if you have an unstable or long term health problem. Skilled nursing care is given under health supervision for nonsurgical care of long term health problems or healing stages of short term health problems or injuries. Skilled Nursing Facility coverage does not include care for Members with significant medical needs. Also, benefits are not available for Custodial Care.

Where covered, there may be separate limits on the number of days We cover for skilled nursing care. To learn more, see the *Summary of Benefits.* If you use up the number of days allowed, or if We determine that you reached Maximum Medical Improvement and no further major changes can be made, further Skilled Nursing Facility services will be denied.

# Outpatient Services

Outpatient Services are for both Facility and professional Provider charges when given to you in an Outpatient location. These can be places like a Hospital, Alternative Care Facility or other Facility Provider. Professional charges include services billed by a Doctor or other professional Provider in the outpatient location. Your Cost Sharing requirements may be greater depending on where the service is performed. To learn more, please see the Schedule of Benefits.

The services covered for “Inpatient Services” listed above are also covered for “Outpatient Services”. What is not covered is the room, board and general nursing services.

# Diagnostic Services

Coverage for test are covered when they are done as part of preventive care services, Doctor office services, infertility diagnostic services, outpatient services, home care services, hospice services, Emergency care and Urgent Care. Covered Services include:

* X-ray and other radiology.
* Lab and pathology.
* CT, MRI, MRA, PET tests.
* Ultrasounds.
* Allergy tests.
* Hearing tests, unrelated to an exam for prescribing or fitting of a hearing aid, except as required by law.
* Genetic tests if those tests are allowed by Our medical plan.
* Ultrafast CT scans when precertified and if those tests are allowed by Our medical plan.

# Surgical Services

Surgery services are covered when part of a Doctor office service, or on an inpatient or outpatient basis for:

* Surgery or other types of operative services.
* Treating broken bones and dislocations.
* Sterilization services.
* Anesthesia and for an assistant surgeon, but only if allowed by Our medical plan. We do not pay for all surgical assistant procedures.
* Normal and related care, before and after Surgery.
* Bariatric surgery and complications from bariatric surgery that satisfy Our medical policy and which are received from a designated facility are covered benefits. See the Schedule of Benefits for benefit limitations.
* Other types of services as approved by Us.

The surgical fee includes usual follow-up care that is Medically Necessary.

**Note:** If you are getting benefits for a covered mastectomy or for follow-up care for a covered mastectomy, and you decide to have breast reconstruction, you will also get coverage for:

* Reconstruction of the breast on which the mastectomy has been performed.
* Surgery and reconstruction of the other breast to give a balanced look; and
* Prostheses and for physical problems caused by any stage of the mastectomy, including lymphedemas.

This coverage will be provided in consultation with you and your attending physician and will be subject to the same Coinsurance, Copayment provisions otherwise applicable under the plan.

### Transgender Surgery

This coverage provides benefits for many of the charges for transgender surgery (also known as sex reassignment surgery), where Medically Necessary as determined by our medical policies and guidelines. Covered Services must be approved by Us and must be authorized by Us prior to being performed. **Changes for services that are not authorized for the surgery requested will not be considered Covered Services. Some conditions apply, and all services must be authorized by us as outlined in the "How to Access Your Services and Obtain Approval of Benefits" section.**

# Emergency Care and Urgent Care

If you are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment. **Services from an Emergency Care Provider, but which are provided for conditions that do not meet the definition of Emergency will not be covered.**

### Emergency Services

Benefits are available in a Hospital Emergency Room for services and supplies to treat the onset of symptoms for an Emergency, which is defined below.

### Emergency (Emergency Medical Condition)

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

### Emergency Care

“Emergency Care” means a medical or behavioral health exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

In cases of Emergency, services are covered from either an In-Network Provider or Out-of-Network Provider. For Emergency Care from an Out-of-Network Provider, you will not need to pay more than what you would have if you had seen an In-Network Provider.

We cover Emergency Care needed to screen and Stabilize you without Precertification. But once you are stabilized any further or follow-up care is not considered Emergency Care. If you continue to get care from an Out-of-Network Provider, Covered Services will not be available unless we agree to cover them as an Authorized Service.

When you are admitted as an inpatient straight from a Hospital Emergency room, the Emergency room Copayment will be waived. For inpatient admissions after Emergency Care, you should get in touch with Us within seventy-two hours of being admitted or as soon as reasonably possible to obtain authorization for the continued stay.

### Urgent Care

Sometimes the type of you care you need is Urgent and it not an Emergency. Urgent Care can be received from an In- Network Provider or an Out-of-Network Provider. For Urgent Care from an Out-of-Network Provider, you will not need to pay more than what you would have if you had seen an In-Network Provider. If you have an Accidental Injury or a medical problem, We will decide whether your injury or medical problem is Urgent Care or Emergency Care for coverage purposes, based on your diagnosis and symptoms.

Urgent Care is when you need immediate medical attention but your condition is not life-threatening (non-Emergency). Treatment of an Urgent Care health problem is not an Emergency and does not need the use of an emergency room at a Hospital. If you call your Doctor before receiving care for an urgent health problem and you are told to go to an emergency room, your care will be paid at the level specified in the *Summary of Benefits* 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 make sure you receive coverage:

* Know the difference between an Emergency and an Urgent Care situation.
* If you are having an Emergency, call 9-1-1 or go to the nearest Hospital. If you are having an Urgent Care health problem, go to an Urgent Care Center or your Doctor’s office. If there is not one nearby, then go to the Hospital.
* Call your Doctor or Us within seventy-two hours or as soon as you reasonably can.
* 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 Doctor. If the Hospital or Urgent Care Center 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 any cost shares as stated in your *Summary of Benefits*.
* You will receive an Explanation of Benefits form.

# Ambulance and Transportation Services

Medically Necessary Ambulance and Emergency Ambulance services are Covered Services when one or more of the following criteria are met:

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

Ambulance services are subject to Medical Necessity reviews by Us. Emergency Ambulance services do not require Precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. For Emergency Ambulance services from by an Out-of-Network Provider you do not need to pay any more than would have been paid for services from an In-Network Provider.

Non-Emergency Ambulance services are subject to Medical Necessity reviews by Us. Air ambulance services for non- Emergency Hospital to Hospital transfers and all scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. See the section “How To Access Your Services and Obtain Approval of Benefits” under the “Getting Approval for Benefits” for more information. When using an air Ambulance for non-Emergency transportation, We reserve the right to select the air Ambulance Provider. For non-Emergency services if you do not use the air Ambulance Provider We select services will not be covered.

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

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

### Important Notes on Air Ambulance Benefits

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

Air Ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if you are taken to a Doctor’s office or your home.

### Hospital to Hospital Transport

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

# Therapy Services

The following therapy services are covered when done in the Doctor’s office, as part of an inpatient admission, when done outpatient or as part of Home Care service.

### Physical, Speech, and Occupational Therapy

For children under age 6, We cover at least 20 visits, each, of physical, speech and occupational therapy. Benefits include the treatment of Congenital Defects and Birth Abnormalities, even if it a long term condition. It also doesn’t matter if the

reason for therapy is to maintain (not improve) the child’s skills. For children between 3 and 6 with Autism Spectrum Disorders, We cover more than 20 visits of each therapy if part of a Member’s Autism Treatment Plan and determined Medically Necessary by Us.

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.

If you are 6 or older, We cover the number of visits listed on the *Summary of Benefits.* Coverage is given only if the physical, speech or occupational therapy will result in a practical improvement in the level of functioning in a short period of time and is Medically Necessary.

* **Physical therapy** includes care by physical means like, hydrotherapy, heat or like modalities, physical agents, bio- mechanical and neuro-physiological principles and devices. Physical therapy is given to help pain, return function and to prevent disability after a health problem, or as a result of a Congenital Defect or Birth Abnormality.
* **Speech therapy** is covered where We decide it’s Medically Necessary to correct a speech problem caused by an injury, health problem or Congenital Defect or Birth Abnormality. For a cleft palate or cleft lip, Medically Necessary speech therapy is not limited, but those visits lower the number of speech therapy visits available to treat other problems.
* **Occupational therapy** is covered to treat physical disabilities or a Congenital Defect or Birth Abnormality. The therapy needs to be designed to help your ability to do the usual tasks of your daily living or your job.

### Other Therapy Services

* **Chiropractic therapy** services are covered when:
* within the scope of chiropractic care that supports or is needed to help you reach the physical state enjoyed before the health problem.
* the services are usually given to diagnose or treat a neuromusculoskeletal health problem linked to an injury or illness.

Coverage is provided for examinations, office visits with manual adjustment of the spine, x-ray of the spine and conjunctive physiotherapy. Coverage is provided regardless of who provides the Covered Services as long as the Provider is licensed to provide such care. Benefits are up to the number of visits as listed on the *Summary of Benefits*.

* **Cardiac Rehab** to repair an individual’s functional status after a cardiac event. Benefits are allowed at a Facility for exercise and education under the direct supervision of a professional Provider in an intensive outpatient rehab program. From 6 to 36 visits per event are allowed based on Our medical plan.
* **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents. Chemotherapy services can be given at the Providers office. See this “Benefits/Coverage (What is Covered)” section under “Prescription Drugs Administered by a Medical Provider” for more information.
* **Dialysis** treatments for a short term or chronic kidney illness which may include the 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 health problem by the using medicines, water vapors, gases, or anesthetics by inhalation.
* **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. Benefits are up to the number of visits as listed on the *Summary of Benefits*.

### Early Intervention Services

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

This visit limit does not apply to rehabilitation or therapeutic services that are necessary as the result of an acute medical condition or post-surgical rehabilitation or services provided to a child who is not participating in Part C. The coverage for

Early Intervention Services is in addition to any other coverage provided under this Booklet for congenital defects or birth abnormalities.

# Autism Spectrum Disorders

Covered Services are provided for the assessment, diagnosis, and treatment of Autism Spectrum Disorders (ASD The following treatments will not be considered Experimental or Investigational and will be considered appropriate, effective, or efficient for the treatment of Autism Spectrum Disorders where We determine such services are Medically Necessary:

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

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

Coverage of Autism Spectrum Disorders in this “Benefits/Coverage (What Is Covered)” section is in addition to coverage provided for early intervention and Congenital Defects and Birth Abnormality. Autism services and the Autism Treatment Plan are subject to review under the “How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)” section.

# Home Care/Home IV Therapy Services

Home health services are performed by a Home Health Care Agency or other Provider in your home. They must be given on a part-time visiting basis for your course of treatment. Refer to your *Summary of Benefits* for benefit limitations. Covered Services include the following:

* Professional nursing services you get from a registered nurse (R.N.) or a licensed practical nurse (L.P.N).
* Health care/social services.
* Diagnostic services.
* Nutritional guidance.
* Certified nurse aide services under the supervision of an R.N. or a therapist skilled in professional nursing services.
* Therapy Services like physical, occupational, respiratory, inhalation, speech and hearing therapy. Therapy services are not subject to therapy limits listed under the *Summary of Benefits* when provided by a Home Health Care Agency.
* Social work practice services from a social worker;
* Medical and surgical supplies.
* Durable medical equipment.
* Prescription Drugs but only if provided and billed by a Home Health Care Agency.

### Home IV Therapy

Home IV therapy is covered and includes a mixture of nursing care, durable medical equipment and IV pharmaceutical services. These are delivered and/or given 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 after a Hospital discharge when it is Medically Necessary. More days may be given up to a maximum of 42 days per Benefit Period when precertified by Us. Aside from the limits above, home IV therapy services are not subject to the home health care limits listed on the *Summary of Benefits*.

See this “Benefits/Coverage (What is Covered)” section under the “Prescription Drugs Administered by a Medical Provider” for more information.

# Nutritional Counseling

Nutritional counseling is a way of looking at your food habits and choices with a food expert who offers diet changes and food ideas right for you. The goal of nutrition counseling is to make the right food choices, and improve the nutritional value and dietary supplements in your diet. Benefits are given for a registered dietitian who is a health worker who knows about diet and foods and who is able to translate that information into the right food choices. Registered dietitians must limit their practice to those methods which conform with applicable laws. We cover up to a 60 minute session for each visit listed on the *Summary of Benefits*.

Benefits include:

* Nutritional techniques of evaluation which give measurements and changes.
* Nutritional counseling.
* Nutritional therapy.
* Help on nutritional supplements.

Coverage is not given for foods, hypnosis, personal training, supplements or vitamins.

Nutritional counseling for the treatment of eating disorders, such as anorexia nervosa and bulimia nervosa is covered under the “Mental Health and Substance Abuse Services” section.

Nutritional counseling provided as part of a preventive visit will be covered under “Preventive Care Services”.

Nutritional counseling provided as part of diabetes management will be covered under “Diabetes Management Services”. Benefit will be based on place of service.

# Medical Foods

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

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

These benefits do not include enteral nutrition therapy or medical foods for Members with cystic fibrosis or lactose- or soy- intolerance. Also all covered medical foods must be obtained through an In-Network Pharmacy and are subject to the pharmacy payment requirements.

# Hospice Care

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

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

Your Doctor and Hospice medical director must certify that you are terminally ill and likely have less than six months to live. Your Doctor must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to Us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Member in Hospice. These additional Covered Services will be covered under other parts of this Booklet. Any care you get that has to do with an unrelated illness or medical condition will be subject to the provisions of this plan that deals with that illness.

# Human Organ and Tissue Transplant Services

Covered Services are paid as inpatient services, outpatient services, or Doctor home visits and offices services depending on where the services is given and subject to your cost shares.

### Covered Transplant Procedure

We cover Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and transfusions as determined by Us when precertified. This includes Medically Necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies.

Covered transplant procedures include:

* Heart.
* Lung (single or double).
* Heart-Lung.
* Kidney-Pancreas.
* Pancreas.
* Liver.
* Bone Marrow/Peripheral Stem Cell/Cord Blood;
* Small bowel.
* Multivisceral.

This list may change based on Our medical plan. If you are eligible for Medicare (or think you will be in the future), it is up to you to contact Medicare to see if you transplant will be covered by Medicare.

Immunosuppressant drugs prescribed for outpatient used with a covered human organ and tissue transplant that are given 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.

Coverage includes Covered Services for the live donor and/or donated organ or tissue. This can be for such things as Hospital, surgical, medical, storage and transportation costs (including problems from the donor procedure for up to 6 weeks from the date of getting the organ).

Benefits include unrelated donor searches from an authorized licensed registry for bone marrow/stem cell transplants for a covered transplant procedure. Benefits for donor searches that are not part of your family for bone marrow/stem cell donor searches are limited to the maximum as listed on the *Summary of Benefits*.

### In-Network Transplant Provider

A Provider that We have chosen as a “Center of Excellence” and/or a Provider selected to take part as an In-Network transplant Provider by the Blue Cross and Blue Shield Association. The Provider has entered into a transplant Provider agreement to give covered transplant procedures and certain administrative duties for the transplant network. A Provider may be an In-Network transplant Provider for:

* Certain covered transplant procedures.
* All covered transplant procedures.

### Transplant Benefit Period

At an In-Network transplant Provider Facility, the Transplant Benefit Period starts one day prior to a covered transplant procedure and lasts for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network transplant Provider agreement. Call the case manager for specific In-Network transplant Provider details for services received at or coordinated by an In-Network transplant Provider Facility. At the end of the case rate / global time period, benefit are provided under the “Doctor Office Services”, “Inpatient Services”, and “Outpatient Services” section of the Booklet, depending on where the service is performed and are not subject to the terms of this “Human Organ and Tissue Transplant” section.

### Prior Approval and Precertification

To maximize your benefits, you should call Our transplant department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you to maximize your benefits by giving coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network transplant rules, or exclusions apply. Call the Member Services phone number on the back of your Health Benefit ID Card and ask for the transplant coordinator. Even if We give a prior approval for the covered transplant procedure, you or your Provider must call Our transplant department for Precertification prior to the transplant whether this is performed in an inpatient or outpatient setting.

Precertification is required before We will cover benefits for a transplant. Your Doctor must certify, and We must agree, that the transplant is Medically Necessary. Your Doctor should submit a written request for Precertification to Us as soon as possible to start this process. Not getting Precertification will result in a denial of benefits.

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

### Transportation and Lodging

We will cover the cost of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the covered transplant procedure will be performed. Our help with travel costs includes transportation to and from the Facility, and lodging for the patient and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions. You must send itemized receipts for transportation and lodging costs in a form satisfactory to Us when claims are filed. Call Us for detailed information. Benefits for travel and lodging are limited to the maximum as listed on the *Summary of Benefits*.

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

### Limits

Certain human organ and tissue transplant services may be limited. See the *Summary of Benefits*.

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

* Kidney.
* Cornea.
* Any Covered Services for a covered transplant procedure received before or after the Transplant Benefit Period. Note: the collection and storage of bone marrow/stem cells is included in the covered transplant procedure benefit above no matter the date of service.

The above Covered Services are paid as “Doctor Office Services”, “Inpatient Services”, and “Outpatient Services” under this Booklet depending on where the service is performed. Benefits are not covered for transportation, lodging and meals for those services listed above.

# Medical Supplies, Durable Medical Equipment, and Appliances

The supplies, equipment and appliances described below are covered under this benefit. But if We decide that the medical supply, equipment and/or appliances includes comfort, luxury or convenience items or features that exceed what is Medically Necessary for your situation, We only allow up to the Maximum Allowed Amount for a standard covered item that serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

### Medical and Surgical Supplies

We cover syringes, needles, oxygen, surgical dressings, splints and other like items that serve only a health purpose, including diabetic supplies.

### Durable Medical Equipment

We cover the rental (or, at Our choice, the purchase) of durable medical equipment prescribed by a Doctor or other Provider. The rental cost must not be more than the price to buy the equipment. This equipment must serve only a health care purpose and be able to withstand repeated use. If We cover a piece of medical equipment, We also cover the repair of that equipment.

### Prosthetic Devices

We cover purchase, fitting, needed changes, 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 a permanently ineffective or non-functioning body part.

We also cover prosthetic arms and legs to the benefit amounts provided by federal laws for Medicare or where needed to meet state insurance law.

Benefits for prosthetic devices include:

* Either one set of standard prescription glasses or one set of contact lenses (whichever is right for the health problem) when needed 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 bras each Benefit Period after a mastectomy.
* The first wig after cancer treatment, up to any maximum listed on the Summary of Benefits.

### Orthopedic Appliances

We cover the purchase, fitting, needed changes, repairs, and replacements of Orthopedic Appliances and supplies. These are rigid or semi-rigid supportive devices and items that limit or stop motion of a weak or diseased body part.

Foot Orthotics and orthopedic shoes are not covered (unless you have diabetes).

# Hearing Aid Services

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

* Audiological testing to measure the level of hearing loss and to choose the proper make and model of a hearing aid. These evaluations will be provided under other benefits of this “Benefits/Coverage (What Is Covered)” section for diagnostic services.
* Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment. We cover auditory training when it is offered using approved professional standards. Initial and replacement hearing aids will be supplied every 5 years, a new hearing aid will be a covered service when alterations to your
* Visits for fitting, counseling, adjustments and repairs after receiving the covered hearing aid.

# Dental Related Services

### Accident-Related Dental Services

This Booklet is not meant to provide or replace dental insurance. Benefits are provided for dental work and oral Surgery if they are for the initial repair of an Accidental Injury to the jaw, sound natural teeth, or related body tissue, mouth or face and only 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, unless the chewing or biting results from a medical or mental condition.

### Dental Anesthesia

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

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

### Cleft Palate and Cleft Lip Conditions

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

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

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

### Other

The only other dental costs that are Covered Services are facility charges for inpatient and/or outpatient services. Benefits are payable in such settings only if the Member’s health problem or the dental treatment calls for it to keep you safe.

# Mental Health and Substance Abuse Services

We cover inpatient services, outpatient services and Doctor office services for the care of Mental Health and Substance Abuse. These services include diagnosis, crisis intervention and short-term care of mental health conditions and for rehab of substance dependency.

Coverage for mental health care is for a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition. Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) care is covered under this section if the services are given by a mental health Provider.

Substance Dependency benefits are for acute medical detox and for rehab. This care is covered when given by a covered Provider Center. Substance Dependency is what happens when you use alcohol or other drugs in a way that harms your health or destroys your ability to control your actions. The main reason for medical detox is to get rid of the toxins in your body, and check your heart rate, blood pressure and other vital signs. Medical detox helps with your withdrawal signs and it gives you medicines as needed. Rehab includes the services and treatment listed below, to help you stop abusing alcohol or drugs.

We also cover medicine management for Mental Health and Substance Abuse when given by your medical Doctor, psychiatrist or prescriptive nurse. If the medicine management is given by your medical Doctor, benefits are paid under your medical benefit. If medicine management is given by a psychiatrist or prescriptive nurse, benefits are paid under your mental health benefit. For coverage of Prescription Drugs, see this “Benefits Coverage (What Is Covered)” section, under the “Retail or Home Deliver (Mail Order) Pharmacy” benefit.

**Inpatient Services.** Inpatient care to treat Mental Health and Substance Abuse includes:

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

**Residential Treatment.** Care at a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:

* Observation and assessment by a physician weekly or more often.
* Rehabilitation, therapy, and education.

**Partial Hospitalization Services**. The same services covered for outpatient services for Mental Health and Substance Abuse are covered when you are in the Hospital for only part of the day. Partial hospitalization treatment is covered only when you receive Medically Necessary care through a day treatment program as decided by the facility.

**Outpatient Services**. The same services listed above for inpatient are covered on an outpatient basis. What are not covered are room, board and general nursing services. Outpatient services include intensive outpatient treatment[, and Intensive In- Home Behavioral Health Services].

**Online Visits.** When available in your area, your coverage will include online visit services. Covered Services include a visit using the web by webcam, chat or voice. Covered Services are provided when received from an In-Network Provider and are not covered when received from an Out-of-Network Provider.

**Precertification**. Your Doctor should call Our behavioral health administrator to find out Medical Necessity needs, correct treatment level and proper setting. Non-Emergency inpatient services need Precertification. See the “How to Access Your Services and Obtain Approval of Benefits” section for under “Getting Approval for Benefits” information

# Prescription Drugs Administered by a Medical Provider

We cover Prescription Drugs, including Specialty Drugs, that must be, administered to you as part of a Doctor’s visit, home care visit, or at an outpatient Facility when they are Covered Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to you in a medical setting. Benefits for Drugs

that you inject or get through your Pharmacy benefits (i.e., self-administered Drugs) are not covered under this section. Benefits for those Drugs are described in the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section.

### Important Details About Prescription Drug Coverage

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

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

* Quantity, dose, and frequency of administration,
* Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
* Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
* Step therapy requiring one Drug or a Drug regimen or another treatment be used prior to use of another Drug or Drug regimen for safety and/or affordability when clinically similar results may be anticipated and one option is less costly than another,
* Use of an Anthem Prescription Drug List (a formulary developed by Us) which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

### Precertification

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

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

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

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

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

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

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

Please refer to the section “How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)” under “Getting Approval for Benefits” for more details.

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

### Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call Member Services at the phone number on the back of your Health Benefit ID Card.

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

Your Plan also includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery (Mail Order) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

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

## Prescription Drug Benefits

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

### Prior Authorization

Prescribing Providers must obtain prior authorization in order for you to get benefits for certain Drugs. At times, your Provider will initiate a prior authorization on your behalf before your Pharmacy fills your prescription. At other times, the Pharmacy may make you or your Provider aware that a prior authorization or other information is needed. In order to determine if the Prescription Drug is eligible for coverage, We have established criteria.

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

* Quantity, dose, and frequency of administration,
* Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
* Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
* Step therapy requiring one Drug or a Drug regimen or another treatment be used prior to use of another Drug or Drug regimen for safety and/or affordability when clinically similar results may be anticipated and one option is less costly than another,
* Use of a Prescription Drug list (as described below).

You or your Provider can get the list of the Drugs that require prior authorization by calling member services at the phone number on the back of your Health Benefit ID Card or check our website at [www.anthem.com.](http://www.anthem.com/) The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Provider may check with us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

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

**Expedited** prior authorization – We will review Expedited requests for prior authorization of Prescription Drugs according to the timeframes listed below:

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

**Non-Expedited** prior authorization – We will review non-Expedited requests for prior authorization of Prescription Drugs according to the timeframes listed below:

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

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

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

## Covered Prescription Drugs

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

Benefits are available for the following:

* Prescription Legend Drugs from either a Retail Pharmacy or the PBM’s Home Delivery Pharmacy;
* Specialty Drugs;
* Self-administered Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the “Prescription Drugs Administered by a Medical Provider” benefit;
* Self-injectable insulin and supplies and equipment used to administer insulin;
* Certain supplies, equipment and appliances (such as those for diabetes). You may contact Us to determine supplies covered through a Pharmac;
* Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings. Certain contraceptives are covered under the “Preventive Care Services” benefit. Please see that section for more details;
* Special food products or supplements when prescribed by a Doctor if We agree they are Medically Necessary;
* Flu Shots (including administration). These will be covered under the “Preventive Care Services” benefit;
* Immunizations (including administration) required by the “Preventive Care Services” benefit;
* Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the “Preventive Care Services” benefit;
* FDA-approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a prescription for a Member age 18 or older. These products will be covered under the “Preventive Care Services” benefit;
* Compound drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved and require a prescription to dispense, and are not essentially

the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

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

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

## Where You Can Get Prescription Drugs

### In-Network Pharmacy

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Health benefit ID Card and they will file your claim for you. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when you get the Drug. If you do not have your Health Benefit ID Card, the Pharmacy will charge you the full retail price of the prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

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

You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. A Maintenance Medication is a Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure the Prescription Drug you are taking is a Maintenance Medication or need to determine if your Pharmacy is a Maintenance Pharmacy*,* please call member services at the number on the back of your Health Benefit ID Card or check Our website at [www.anthem.com](http://www.anthem.com/) for more details.

### Specialty Pharmacy

We keep a list of Specialty Drugs that may be covered based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time. We may require you or your doctor to order certain Specialty Drugs from the PBM’s Specialty Pharmacy.

When you use the PBM’s Specialty Pharmacy, its patient care coordinator will work with you and your Doctor to get prior authorization and to ship your Specialty Drugs to your home or your preferred address. Your patient care coordinator will also tell you when it is time to refill your prescription.

Certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy.

You can get the list of covered Specialty Drugs by calling member services at the phone number on the back of your Health Benefit ID Card or check our website at [www.anthem.com.](http://www.anthem.com/)

### Home Delivery Pharmacy

The PBM also has a Home Delivery Pharmacy which lets you get certain Drugs by mail if you take them on a regular basis. You will need to contact the PBM to sign up when you first use the service. You can mail written prescriptions from your Doctor or have your Doctor send the prescription to the Home Delivery Pharmacy. Your Doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when you ask for a prescription or refill.

You must get covered Prescription Drugs and supplies from an In-Network Pharmacy, if you don’t they will not be covered.

### Out-of-Network Pharmacy

You must get covered Prescription Drugs and supplies from an In-Network Pharmacy, if you don’t they will not be covered.

## What You Pay for Prescription Drugs

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

* Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, or Interchangeable Biologic Products.
* Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, or Interchangeable Biologic Products.
* Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, or Interchangeable Biologic Products.
* Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, or Interchangeable Biologic Products.

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

### Prescription Drug List

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

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

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

## Additional Features of Your Prescription Drug Pharmacy Benefit

### Day Supply and Refill Limits

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

If you are going on vacation and you need more than the day supply allowed, you should ask your pharmacist to call Our PBM and ask for an override for one early refill. If you need more than one early refill, please call member services at the number on the back of your Health Benefit ID Card.

### Half-Tablet Program

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

### Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctors about alternatives to certain prescribed Drugs. We may contact you and your Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. For questions or issues about therapeutic Drug substitutes, call member services at the phone number on the back of your Health Benefit ID Card.

### Special Programs

Except when prohibited by federal regulations (such as HSA rules), from time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. We may stop a program at any time. If you are participating in a program that We have stopped We will give you at least a 30-day advance written notice of the discontinuance.

# Clinical Trials

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

Benefits are limited to the following trials:

* Federally funded trials approved or funded by one of the following:
* The National Institutes of Health.
* The Centers for Disease Control and Prevention.
* The Agency for Health Care Research and Quality.
* The Centers for Medicare & Medicaid Services.
* Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
* A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
* Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

i The Department of Veterans Affairs. ii The Department of Defense.

iii The Department of Energy.

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

We may require that you use an In-Network Provider to maximize your benefits.

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

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

We are not required to provide benefits for the following services. We reserve Our right to exclude any of the following services:

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

# LIMITATIONS/EXCLUSIONS (What is Not Covered)

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

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

1. That We find 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 “Emergency Care and Urgent Care” under the “Benefits/Coverage (What Is Covered)” section of this Booklet.
2. For care received from an Out-of-Network Provider, except for Emergency Care, Urgent Care or as precertified by Us as a Covered Service.
3. Received from someone or an entity that is not a Provider, as defined in this Booklet.
4. That are Experimental or Investigational or related to such, whether incurred before, in connection with, or subsequent to the Experimental or Investigational service or supply, as determined by Us.
5. That could be paid as benefits through any governmental unit (except Medicaid), unless otherwise required by law. The payment of benefits under this Booklet will be coordinated with such governmental units as required by state and/or federal laws.
6. For which benefits would be paid by Medicare Part A and/or Part B, unless otherwise stated in this Booklet or prohibited by federal law. See “Medicare” under the “General Plan Provisions” section of this Booklet.
7. In excess of the Maximum Allowed Amount unless otherwise stated in this Booklet.
8. Incurred before your Effective Date.
9. Incurred after the end date of this coverage unless otherwise stated in this Booklet.
10. For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Cosmetic Services have the intent to preserve, change or improve your appearance. Or they are for psychiatric or psychological reasons. There is no coverage for Surgery or treatments to change the texture or appearance of your skin. There is no coverage 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 specifically required by law.
11. For services done to maintain or preserve the present level of function or prevent regression of function for a condition that is resolved or stable.
12. For Dental Services. Excluded dental services include, but are not limited to, preventive care and fluoride treatments; dental x-rays, supplies, appliances and all associated expenses; and diagnosis and treatment related to the teeth, jawbones or gums such as extraction (including dental prosthesis and any treatment for teeth, gums, tooth or upper or lower jaw augmentation or reduction (orthognathic Surgery), extraction of impacted wisdom tooth), restoration and replacement of teeth, and services to improve dental clinical outcomes. This exclusion does not apply to services which We are required by law to cover; services to prepare the mouth for radiation therapy to treat head and/or neck cancer; and services specified as covered in this Booklet.
13. Weight loss programs including treatment for obesity, whether or not they are under a medical or Doctor’s care, unless otherwise stated in this Booklet. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight loss) and fasting programs.
14. Treatment of obesity, except for surgical treatment of morbid obesity (bariatric Surgery) up to the maximum benefit as listed on the *Schedule of Benefits*;
15. Services provided by an Emergency Care Provider for conditions that do not meet the definition of Emergency. This includes, but is not limited to, suture removal in an emergency room.
16. For research studies or screening exams, unless otherwise stated in this Booklet.
17. For stand-by charges of a Doctor.
18. Shots for travel.
19. Routine exams and shots that are needed 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 Health Services or Hospice Care services under the “Benefits/Coverage (What Is Covered)” section of this Booklet.
21. Related to male or female sexual or erectile dysfunction or inadequacies, no matter what origin or cause. This includes all procedures, and equipment developed for or used in the treatment of impotency.
22. Nutritional and/or dietary supplements, unless otherwise stated in this Booklet or as required by law. This exclusion includes those nutritional formulas and dietary supplements that can be bought over the counter, which by law do not require either a written Prescription Drug 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 Doctor.
25. For services or supplies for Intractable Pain and/or Chronic Pain.
26. Services that are more than the Benefit Period maximum payments as listed in the Booklet or *Summary of Benefits*

even if you have satisfied the Out-of-Pocket Annual Maximum.

1. Breast reduction Surgery (reduction mammoplasty) or services related to it, except as required by law or We determine such services are Medically Necessary.
2. For any condition, disease, defect, ailment or injury arising out of and in the course of employment, except for officers of the company who have opted out of workers’ compensation before the illness or injury. This exclusion applies even if some or all benefits in whole or in part under any Workers’ Compensation Act or other similar law are not paid. This 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 stated in “General Plan Provisions” section of this Booklet.
3. For anything 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.
4. For a condition resulting from a riot, civil disobedience, nuclear explosion or nuclear accident;
5. For testing or care that has been ordered by a court unless Medically Necessary and precertified by Us.
6. For which you have no legal obligation to pay in the absence of this or like coverage.
7. That you get from a dental or medical department run by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
8. Prescribed, ordered or referred by, or received from, a member of your immediate family (parent, child, spouse, sister, brother or self).
9. For filling out claim forms or charges for medical records or reports, unless otherwise required by law.
10. For missed or canceled appointments.
11. For mileage or other travel costs, except if We approve it.
12. For Custodial Care, or domiciliary or convalescent care, whether or not recommended or performed by a professional.
13. For foot care to improve comfort or appearance. This includes, but not limited to, care for flat feet, subluxations, corns, bunions (except capsular and bone Surgery), calluses and toenails.
14. For marital counseling or personal growth.
15. For eyeglasses, contact lenses or their fitting, vision therapy or routine vision exams, unless otherwise stated in this Booklet.
16. For hearing aids, unless otherwise stated in this Booklet.
17. For services or supplies mainly for educational, vocational, or training purposes, unless otherwise stated in this Booklet.
18. Services to reverse voluntarily induced sterility.
19. Services of any type for the treatment of infertility.
20. For services (including speech therapy) for dysfunctions that are self correcting. This includes language therapy for young children with natural dysfluency or developmental articulation errors that are self correcting. It also includes learning and behavior problems, hyperkinetic syndromes or mental retardation (except for Prescription Drugs for treatment of these conditions if Prescription Drugs are covered).
21. For personal hygiene services, self help devices that are not medical in nature, or services and supplies for comfort and ease;
22. For care related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy.
23. Health club memberships, exercise equipment, charges from a fitness or personal trainer, or any other charges for physical fitness, even if ordered by a Doctor. This also applies to health spas.
24. For self help training and other forms of self care that are not medical in nature, unless otherwise stated in this Booklet.
25. For hair loss treatment, even if the hair loss is caused by a medical condition, except for alopecia areata or as otherwise stated in this Booklet.
26. For peripheral bone density scans;
27. For storage or other administrative costs, except when provided as part of the Inpatient Services and Human Organ and Tissue Transplant Services under the “Benefits/Coverage (What Is Covered)” section of this Booklet.
28. For medical, surgical services and appliances related to temporomandibular joint (TMJ) therapy regardless of Medical Necessity;
29. For the cost of donor sperm or donor eggs, storage costs for sperm or frozen embryos, or tests to see if a procedure to promote fertility or pregnancy is effective;
30. Provided or billed by a school, halfway house, or outward bound program, even if psychotherapy is included.
31. For rolfing therapy, myotherapy or prolotherapy;
32. Ambulance services when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family or Doctor. Other non-covered Ambulance services include, but are not limited to, trips to Doctor’s office, clinic, morgue or funeral home.
33. For Foot Orthotics, orthopedic shoes and arch supports (except if you are diagnosed with diabetes).
34. For air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, wristlets, augmentative communication devices, surgical supports, and corsets or other articles of clothing, unless otherwise stated in this Booklet.
35. Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.
36. For items most often stocked in the home for general use like Band-Aids, thermometers and petroleum jelly.
37. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for Cosmetic purpose.
38. For any services or supplies provided to a person not covered under the Booklet in connection with a surrogate pregnancy. This includes, but not limited to, the bearing of a child by another woman for a couple who cannot have a child.
39. For gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
40. Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center.
41. Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, even if written as a prescription, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Health Benefit ID Card, or visit our website at [www.anthem.com.](http://www.anthem.com/)
42. Language training for delays in education, psychology or in speech.
43. Hobbies, arts and crafts that are a diversion, for recreation, or vocational in nature.
44. Cardiac Rehab home programs, which also includes on-going care.
45. Related to alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), biofeedback, chelating agents (except for treatment of heavy metal poisoning) and iridology;
46. For massage therapy.
47. For acupuncture/nerve pathway therapy.
48. For phone or fax communications between a Provider and Member for Telemedicine.
49. For any of the following if done in connection with online visit services, such as reporting normal lab or other test results, office appointment requests, billing, insurance or payment questions, requests for referrals to Doctors outside the online care panel, benefit Precertification, and Doctor to Doctor consultation.
50. Providers that are not licensed by law to provide Covered Services, as defined by this Booklet.
51. We do not cover services rendered by Providers located outside the United States, unless the services are for Emergency Care, Urgent Care and emergency ambulance.

### Human Organ and Tissue Transplant Services:

1. Human organ and tissue transplant services that are not done by an In-Network transplant Provider for the organ or tissue being transplanted.
2. If you are not a suitable candidate as determined by the In-Network transplant Provider to provide human organ and tissue transplant services.
3. Benefits for services for donor searches or tissue matching, or personal living costs related to donor searches or tissue matching, for the recipient or donor, or for their family members or friends except as covered.
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 “Benefits/Coverage (What Is Covered)” section in this Booklet including non-human organs.
6. Procurement of a donor organ which has been sold rather than donated.
7. Related to artificial and/or mechanical hearts or for subsequent services and supplies for a heart condition as long as any of the artificial or mechanical heart remains in place. This exclusion includes services for implantation, removal and complications.
8. For non-covered transportation and lodging costs related but not limited to the following:
   * Alcohol, tobacco, other non-food items.
   * Meals.
   * Child care.
   * Mileage within the medical transplant Facility city.
   * Rental car, buses, taxis, or shuttle services, except those that We approve.
   * 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.
   * Phone calls.
   * Laundry.
   * Postage.
   * Entertainment.
   * Interim visits to a medical care facility while waiting for the actual transplant procedure.
   * Travel costs for donor companion/caregiver.
   * Return visits for the donor for a treatment of an illness found during the evaluation.

### 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, unless otherwise specified in this Booklet.
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 medications used to treat infertility.
8. Delivery charges for prescriptions.
9. Charges for the administration of any drug unless dispensed in the Doctor’s office or through home health care.
10. Drugs which are provided as samples to the Provider.
11. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse.
12. Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of the “Benefits/Coverage (What Is Covered)” section.
13. Therapeutic devices or appliances, including support garments and other nonmedicinal supplies (regardless of intended use).
14. Over-the-counter items drugs, devices and products, or Prescription Drugs with over the counter equivalents and any drugs, devices or products that are therapeutically comparable to an over the counter drug, device, or product, may not be covered even if written as a prescription. This includes Prescription Drugs when any version or strength becomes available over the counter. This Exclusion does not apply to over-the-counter products that We must cover under federal law with a Prescription.
15. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by applicable law, but not federal law) except for injectable insulin, or where applicable law requires coverage of the drug.
16. Prescription Drugs, which are dispensed in quantities or refill frequency which exceed the applicable limits established by Us, at Our sole discretion.
17. Refills of prescriptions in excess of the quantity prescribed by the Provider, or refilled more than one year from the date prescribed.
18. Prescription Drugs dispensed for the purpose of international travel.
19. Prescription Drugs which have been obtained through a Home Health Care Agency.
20. Replacement of lost or stolen Prescription Drugs.
21. Drugs for treatment of sexual or erectile dysfunction or inadequacies, regardless of origin or cause and even if the dysfunction is a side effect of, or related to another covered disease or illness.
22. When benefits are provided for Prescription Drugs under the ”Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section, they will not also be provided under the “Prescription Drugs Administered by a Medical Provider” section.
23. Any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
24. For gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
25. Compound Drugs unless all of the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

### Chiropractic Therapy

1. Services for preventive, maintenance or well care.
2. Drugs, vitamins, nutritional supplements or herbs.
3. Vocational, stroke, or long-term rehab unless otherwise stated in this Booklet.
4. Hypnotherapy, behavior training, or biofeedback.
5. Rental or purchase of durable medical equipment unless otherwise stated in this Booklet.
6. Treatment for weight control.
7. Lab services.
8. Thermography, hair analysis, heavy metal screening of mineral studies.
9. Inpatient services.
10. Manipulation under Anesthesia.
11. Treatment of non-neuromusculoskeletal disorders.
12. Advance diagnostic services such as MRI, CT, EMG, SEMG, and NCV.

# MEMBER PAYMENT RESPONSIBILITY

# Cost Sharing Requirements

Cost Sharing is how We share the cost of health care services with you. It means what We are responsible for paying and what you are responsible for paying. You meet your Cost Sharing requirements through your payment of Copayments and Coinsurance (as described below). **Please remember that this Plan will not provide benefits for services from Out-of- Network Providers unless the claim is for Emergency Care, Urgent Care, or for services approved in advance by Us as an Authorized Service.**

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

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

The contracts between Us and Our In-Network Providers include a “hold harmless” clause which provides that you cannot be responsible to the Provider for claims owed by Us for health care services covered under this Booklet.

### Maximum Allowed Amount General

This section describes how We determine what We pay for Covered Services. Reimbursement of Covered Services given to you by an In-Network Provider is based on your plan’s Maximum Allowed Amount for the Covered Service that you receive. Please see Inter-Plan Arrangements” in the “Claims Procedure (How to File a Claim)” section for more information.

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

* that meet Our definition of Covered Services, to the extent such services and supplies are covered under this Booklet and are not excluded.
* that are Medically Necessary.
* that are provided with all applicable Precertification, utilization management or other requirements in this Booklet.

You will be required to pay a portion of the Maximum Allowed Amount for Covered Services which are subject to Coinsurance.

Generally, services received from an Out-of-Network Provider under this product are not covered except for Emergency Care, Urgent Care or when allowed as a result of a Referral by Us.

When you receive Covered Services from an In-Network 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 happens, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

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

### Provider Network Status

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

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For Covered Services

performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Services for help in finding an In-Network Provider or visit [www.anthem.com.](http://www.anthem.com/)

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. If you use an Out- of-Network Provider, your entire claim will be denied except for Emergency Care, or unless the services are approved by us as result of a Referral.

For Covered Services You receive from an Out-of-Network Provider for Emergency Care or for services approved as a Referral, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on our managed care fee schedules used with In-Network Providers, which we reserve the right to modify from time to time; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually.
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers’ fees and costs to deliver care, or
4. An amount negotiated by us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management, or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

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

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

Unlike In-Network Providers, Out-of-Network Providers may send you a bill and collect for the amount of the Provider’s charge that exceeds our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant**}**. Please call Member Services for help in finding an In-Network Provider or visit our website at [www.anthem.com.](http://www.anthem.com/)

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

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager (PBM).

### Member Cost Share

For certain Covered Services, and depending on your health benefits plan, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount. For example you would need to pay for your Coinsurance.

Also your Cost Share amount may vary depending on where the service is performed. For example, an outpatient service may have higher cost share if received in a Hospital, instead of a Doctor’s office or Alternative Care Facility. Also your Cost Share amount may vary depending on where the service is performed. For example, an outpatient service may have higher cost share if received in a Hospital, instead of a Doctor’s office or Alternative Care Facility. For example, an outpatient service may have higher cost share if received in a Hospital, instead of a Doctor’s office or Alternative Care Facility. Please

see the *Summary of Benefits* for your cost share amounts and limitations. You can also call Member Services to find out your health benefit coverage or cost share amounts which can vary by the type of Provider you use.

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

Under certain events, if We pay the Provider amounts that are your responsibility, such as Copayments or Coinsurance, We may get those amounts back from you. You agree that We have the right to collect such amounts from you.

### Authorized Services

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.

In some cases, such as where there is no In-Network Provider available for the Covered Service, We may authorize the In- Network Cost Sharing amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you get from an Out-of-Network Provider. In such circumstance, you must contact Us in advance of getting the Covered Service. Please contact Member Services to request authorization.

### Claims Review

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

### Copayment

Copayments may be required for Covered Services. A Copayment is a set, fixed-dollar amount you must pay to receive a specific service. You are required to pay your Copayments to Providers for specific Covered Service as listed in the *Summary of Benefits*. You need to pay Copayments directly to the Provider. Copayments are included in the Out-of-Pocket Annual Maximum.

Your Copayment may be higher for a Specialist than for a Primary Care Provider. The Copayment amounts are listed in the

*Summary of Benefits*.

### Out-of-Pocket Annual Maximum

The Out-of-Pocket Annual Maximum is designed to protect you from catastrophic health care costs. Once you and/or your family have satisfied the Out-of-Pocket Annual Maximum, We pay 100 percent of any remaining eligible changes for the rest of your Benefit Period. The Out of Pocket Annual Maximum is found on the *Summary of Benefits*.

**Family Out-of-Pocket Annual Maximum** - Under a Family Membership, the family Out-of-Pocket Annual Maximum amount is met as follows: When one family Member has satisfied their individual Out-of-Pocket Annual Maximum, no additional Copayments and Coinsurance will be required for that family Member for the remainder of the Benefit Period. The enrolled remaining family Members remain subject to Copayments and Coinsurance until 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 their individual 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 relieved of further Copayments and Coinsurance requirements for the rest of the Benefit Period. No one family member may contribute more than their individual Out-of-Pocket Annual Maximum toward meeting the family Out-of-Pocket Annual Maximum.

The Family Membership Out-of-Pocket Annual Maximum is also applicable for newborn and adopted children (and for all other family Members) for the first 31-day period following birth or adoption if the child is enrolled or not enrolled. If the child is not enrolled during the 31-day period, the Family Membership Out-of-Pocket Annual Maximum will apply during that 31- day period. If other changes in enrollment occur, the amount of and accumulation toward the Family Membership Deductible may also change; please contact Us for information on those situations.

### Benefit Period Maximum

Some Covered Services have a maximum benefit 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 *Summary of Benefits* for those services which have a Benefit Period Maximum.

If you leave this plan, and go on to a new plan with Us in the same Benefit Period, all covered benefits that have a Benefit Period maximum or lifetime maximum will be carried over to the new plan. For instance, if a benefit has a limit of one visit per Benefit Period and you received that benefit under the prior coverage, then you are not eligible under the new plan for the same benefit until the Benefit Period ends, as benefits have been exhausted for your Benefit Period.

# CLAIMS PROCEDURE (How to File a Claim)

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

If an Out-of-Network Provider does not bill Us directly, you must file the claim. To get claim forms, call Our Member Services or print it from Our website at [www.anthem.com.](http://www.anthem.com/) You must complete the claim form and attach the itemized bill from the Provider. Balance due statements, cash register receipts and cancelled checks are not accepted. All information on the claim form and itemized bill must be readable. When traveling outside the country, you should obtain itemized bills translated to English. Charges for Covered Services should be stated in terms of United States dollar. To find out the dollar amount, use the exchange rate as it was on the date you received care. If information is missing on the claim form or is not readable, the form will be returned to you. The information contained on the itemized bills will be used to determine benefits, so it must support information reported on the submitted claim form. The claim form has detailed instructions on how to complete the form and what information is needed.

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

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

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

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

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

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

HMO Colorado Claims

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

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

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

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

### Inter-Plan Arrangements Out-of-Area Services Overview

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

When you receive care outside of the HMO Colorado Service Area, you will receive it from one of two kinds of Providers. Most Providers (“Participating Providers”) contract with the local Blue Cross and/or Blue Shield Plan in that geographic area (“Host Blue”). Some Providers (“Non-Participating Providers”) don’t contract with the Host Blue. We explain below how We pay both kinds of Providers.

We cover only limited healthcare services received outside of the HMO Colorado Service Area. For example, Emergency or Urgent Care obtained outside the HMO Colorado Service Area is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by HMO Colorado**.**

### Inter-Plan Arrangements Eligibility – Claim Types

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

### BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and

(b) handling its interactions with those Providers.

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

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

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

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

### Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, We may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to Us by the Host Blue.

### Special Cases: Value-Based Programs

*BlueCard*® *Program*

If you receive Covered Services under a Value-Based Program inside a Host Blue’s Service Area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Us through average pricing or fee schedule adjustments. Additional information is available upon request.

*Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements*

If We have entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the employer on your behalf, We will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

### Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

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

### Non-Participating Providers Outside Our Service Area

* + 1. **Allowed Amounts and Member Liability Calculation**

When Covered Services are provided outside of Our Service Area by non-Participating Providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-Participating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or applicable law, as applicable, will govern payments for out-of- network Emergency services.

### Exceptions

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

### BlueCard Worldwide® Program

If you plan to travel outside the United States, call Member Services to find out your BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. The Plan only covers Emergency, including ambulance, and Urgent Care outside of the United States. Remember to take an up to date Health Benefit ID card with you.

When you are traveling abroad and need medical care, you can call the BlueCard Worldwide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

### How Claims are Paid with BlueCard Worldwide

In most cases, when you arrange inpatient hospital care with BlueCard Worldwide, claims will be filed for you. The only amounts that you may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

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

* Doctors services.
* Inpatient hospital care not arranged through BlueCard Worldwide.
* Outpatient services.

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

When you need BlueCard Worldwide claim forms you can get international claims forms in the following ways:

* Call the BlueCard Worldwide Service Center at the numbers above.
* Online at [www.bluecardworldwide.com.](http://www.bluecardworldwide.com/)
* You will find the address for mailing the claim on the form.

# GENERAL PLAN PROVISIONS

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

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

For all other changes, such as changes due to state or federal law or regulation, We may amend this Booklet when authorized by one of Our officers. 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 later send or make available to you an amendment to this Booklet or a new Booklet.

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

**Conformity with Law** - any term in this Booklet which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform with the minimum requirements of such laws.

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

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

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

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

* Be wary of offers to waive Copayments, Deductible and/or 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 Member Services.
* Be very cautious about giving your health insurance coverage information over the phone. If fraud is suspected, you should contact Our Member Services.

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

**Independent Contractors -** We have an independent contractor relationship with Our In-Network Providers. Doctors 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 given 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 connected with, any injuries you suffer while receiving care from any of Our In-Network Providers by reason of neglect 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 are experts in certain areas. This may include Prescription Drugs, Mental Health Condition and Substance Abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims payment or Member Services duties on Our behalf.

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

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

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

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

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

**Medicare** - Any benefits covered under both this Booklet and Medicare will be paid pursuant to Medicare Secondary Payer legislation, regulations, and Health Care Financing Administration guidelines, subject to federal court decisions. Federal law controls when there is a conflict among applicable law, Booklet provisions, and federal law. Except when federal law require Us to be the primary payer, the benefits under this Booklet if you are age 65 and older, do not duplicate any benefit for which you are entitled under Medicare, including Part B. We will coordinate benefits with Medicare consistent with applicable law. Where Medicare is the responsible payer, all sums payable by Medicare for services provided to you shall be paid 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 networks in Colorado that addresses your health care needs. The Network Access Plan describes Our Provider network standards for network sufficiency in service, access and availability, as well as assessment procedures We follow in Our effort to maintain adequate and accessible networks. To request a copy of this document, call Our Member Services. This document is also available on Our website or for in-person review at 700 Broadway in Denver, Colorado, in the Member Services.

**Non-Contestable -** This Booklet shall not be contested, except for nonpayment of Premium 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 Booklet with respect to a Member shall be used to avoid the insurance with respect to which statement was made or to reduce benefits under such Booklet after such insurance had been in force for a period of two years during such Member’s lifetime, unless such statement is contained in a written instrument signed by the Member making such statement and a copy of that instrument is or has been given to the Member making the statement or to the beneficiary of any such Member.

**Notice of Privacy Practices -** We promise to protect the private nature of your medical information to the fullest extent of the law. In addition to various laws governing your privacy, We have Our own privacy policies and procedures in place designed to protect your information. We are required by law to provide individuals with notice of Our legal duties and privacy practices. To obtain a copy of this notice, visit Our website at [www.anthem.com](http://www.antheem.com/) or contact Our Member Services.

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

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

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

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

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

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

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

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

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

**Program Incentives** – We may offer incentives from time to time, at our discretion, in order to introduce you to covered programs and services available under this plan. The purpose of these incentives include, but is not limited to, making you aware of cost effective benefit options or services, helping you achieve your best health, and encouraging you to update member-related information. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member cost shares. Acceptance of these incentives is voluntary as long as We offer the incentives program. We may discontinue an incentive for a particular covered program or service at any time. If you have any questions about whether receipt of an incentive or retailer coupon results in taxable income to you, We recommend that you consult your tax advisor.

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

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

**Right of Recovery and Adjustment -** When payment has been made in error, We will have the right to recover such payment from you or the Provider, or otherwise make appropriate adjustment to claims. In most instances such recovery or adjustment activity shall be limited to the calendar year in which the error is discovered.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, vendor, or Subcontractor resulting from these audits if the return of the overpayment is not likely.

Additionally, We have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and settle or compromise recovery and adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount.

**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.

**Statement of ERISA Rights -** The group health care coverage provided by the employer may be offered as part of an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Members shall be entitled to:

*Receive Information About the Coverage and Benefits.*

All plan Members may:

* Examine, without charge, at the plan administrator's office or other specified locations, all documents governing the coverage and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
* Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
* Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each Member with a copy of this summary annual report.

In addition to creating rights for plan Member, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in your interest as well as in the interest of the Subscriber and other plan Members and beneficiaries. No one, including the Subscriber’s employer, or any other person, may fire the Subscriber or otherwise discriminate against the Subscriber in any way to prevent him/her from getting a welfare benefit or exercising rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to get copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules. You must follow the procedures set forth in the “Appeals and Complaints” section.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court, after having exhausted the procedures set forth in the ”Appeals and Complaints” section. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court. The court will decide whom, if anyone should pay court costs and legal fees. If you are successful the court may order the other party(ies) to pay these costs and fees. If you should lose, the court may order you to pay these costs and fees.

*Assistance with Questions*

If you have any questions about the plan, or whether it is a plan governed by ERISA you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the phone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

This benefit plan gives the plan administrator or fiduciary discretionary authority to determine eligibility for benefits and to construe the terms of the Booklet. The plan specifically reserves to the plan administrator or fiduciary the discretion and authority to make such determinations, but where required by applicable law, Our determination may be reviewed de novo (as if for the first time) in a later appeal or legal action. We serve as a claims fiduciary, not as the administrator of your employer’s plan. You should contact your employer to find out who is the plan administrator.

**Value-Added Programs** - We may offer health or fitness related programs to our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under your Plan but are in addition to Plan benefits. As such, program

features are not guaranteed under your health Plan Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

# Workers’ Compensation

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

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

* Occupational disease laws.
* Employer’s liability insurance.
* Municipal, state, or federal law.
* The Workers’ Compensation Act.

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

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

# Automobile Insurance Provisions

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

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

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

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

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

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

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

# Third Party Liability: Subrogation and Right of Reimbursement

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

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

### Subrogation

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

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

### Right of Reimbursement

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

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

### The Member’s Duties

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

# Duplicate Coverage and Coordination of Benefits

We may coordinate benefits when you have coverage with more than one health coverage.

**Duplicate Coverage -** Duplicate coverage is the term used to describe when you are covered by this coverage and also covered by another:

* Group or group-type health insurance.
* Health benefits coverage.
* Blanket coverage.

The Rules for Coordination of Benefits below determine the order in which each plan will pay a claim for benefits. The plan that pays first is the primary plan. The primary plan must pay benefits according to its plan terms regardless of the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

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

The following are not allowable expense:

1. The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the plans provides coverage for private hospital room expenses.
2. If you are covered by two plans that calculate benefits or services on the basis of a usual and customary fees or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.
3. If you are covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the highest of the negotiated rates.
4. If you are covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan’s payment arrangement shall be the allowable expense for all plans. However, if the Provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan’s payment arrangement and if the Provider’s contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
5. The amount of any benefit reduction by the primary plan because you failed to comply with the Plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, Precertification of admissions, and preferred provider arrangements.
6. If you advise us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan’s deductible.

### Order of Benefit Determination Rules – The following rules are used in the order as listed:

**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 plan that does not have order of benefit determination rules will always be primary unless the provisions of both plans state that the plan is primary.

### Non-Dependent or Dependent

The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree, is primary and the plan that covers the person, as a dependent, is secondary. If the person is a Medicare beneficiary, please refer to the section below of “Determining Primacy Between Medicare and Us” for primary and secondary payer rules.

### Active Employee, Retired or Laid-Off Employee

* 1. The plan that covers a person as an active employee, who is not laid off or retired, or a dependent of an active employee, is the primary plan.
  2. If the secondary, or other plan, does not have this rule, and as result the plans do not agree on the order of benefits, this rule is ignored.
  3. This rule does not apply if the section above of “Non-Dependent or Dependent” can determine the order of benefits.

### COBRA or State Continuation Coverage

1. If a person whose coverage is provided in accordance with COBRA, or under a right of continuation according to state or federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree, is the primary plan and the plan covering that same person in accordance with COBRA, or under a right of continuation in accordance with state or other federal law, is the secondary plan.
2. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
3. This rule does not apply if the section above of “Non-Dependent or Dependent” can determine the order of benefits.

### Longer or Shorter Length of Coverage

1. If the rules above do not determine the order of benefits, the plan that covered the person for the longer period of time is primary plan and the plan that covered the person for the shorter period of time is the secondary plan.
2. To determine the length of time a person has been covered under a plan, two (2) successive plans will be treated as one if the covered person was eligible under the second within twenty-four (24) hours after the first ended.
3. The start of a new plan does not include:
   1. A change in the amount or scope of a plan’s benefits.
   2. A change in the entity that pays, provides or administers the plan’s benefits.
   3. A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).
4. The person’s length of time covered under a plan is measured from the person’s first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person’s coverage under the present plan has been in force.

If none of the rules above determine the primary plan, the allowable expense will be shared equally between the plans.

### Dependent Child Covered Under More Than One Plan

Unless there is a court decree stating otherwise, plans covering a dependent child will determine the order of benefits as follows:

1. For a dependent child whose parents are married or are living together, whether or not they have been married:
   1. The plan of the parent whose birthday falls earlier in the calendar year, by month and day, is the primary plan.
   2. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
2. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
   1. If the court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no health care coverage for the dependent child’s health care, but that parent’s spouse does, the spouse’s plan is primary. This item will not apply with respect to a plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
   2. If the court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, paragraph a above will determine the order of benefits.
   3. If the divorce decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the depend child, paragraph a above will determine the order of benefits.
   4. If there is no court decree allocating responsibility for the child’s health care expenses of health care coverage, the order of benefits for the child are as follows:
      1. The plan of the custodial parent.
      2. The plan of the spouse of the custodial parent.
      3. The plan of the noncustodial parent; and then
      4. The plan of the spouse of the noncustodial parent.
3. For a dependent child covered under more than one plan of individuals who are not parents of the child, the order of benefits will be determined, as applicable, according to paragraph a. or b. above as if those individuals were the parents of the child.
4. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in the section above for “Longer or Shorter Length of Coverage” applies.

In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits will be determined by applying the birthday rule to the dependent child's parent(s) and the dependent's spouse.

### Rules for Coordination of Benefits

When a person is covered by two (2) or more plans, the rules for determining the order of benefit payments are as follows:

1. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.
2. If the primary plan is a Closed Panel Plan, and the secondary plan is not a Closed Panel Plan, the secondary plan will pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary provider.
3. When multiple contracts providing coordinated coverage are treated as a single plan, this section only applies to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts.
4. If a person is covered by more than one secondary plan, each secondary plan will take into consideration the benefits of the primary plan, or plans, and the benefits of any other plan, which, has its benefits determined before those of that secondary plan.
5. Under the terms of a Closed Panel Plan, benefits are not payable if the covered person does not use the services of a closed panel provider, with the exceptions of medical emergencies and if there are allowable benefits available. In most instances, Coordination of Benefits does not occur if a covered person is enrolled in two (2) or more Closed Panel Plans

and obtains services from a provider in one of the Closed Panel Plans because the other Closed Panel Plan (the one whose providers were not used) has no liability. However, Coordination of Benefits may occur during the claim determination period when the covered person receives emergency services that would have been covered by both plans.

1. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of any other health coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefit paid or provided by all plans for the claim does not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

### Determining Primacy Between Medicare and Us

We will be the primary payer for persons with Medicare age 65 and older if the policyholder is actively working for an employer who is providing the plan holder’s health insurance and the employer has 20 or more employees. Medicare will be the primary payer for persons with Medicare age 65 and older 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 enrolled with Medicare under age 65 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 in 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 with Medicare under age 65 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. But this will only apply if the group health coverage was primary at the point when the second entitlement took effect, for the duration of 30 months after becoming Medicare entitled or eligible 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

Based on the primacy rules, if Medicare is secondary to a group coverage (see Medicare primacy rules), the primary coverage covering the Member will pay first. Medicare will then 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 policyholder of the group health insurance.

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.

### 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 paid by that coverage, whether or not a claim is made. It also includes benefits that would have been paid but were refused. This is due to the claim not being sent to the Provider of other coverage on a timely basis.

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

### Our Rights to Receive and Release Necessary Information

We may release to, or obtain, from any insurance company or other organization or person any information which We may need to carry out the terms of this Booklet. Members will furnish to Us such information as may be necessary to carry out the terms of this Booklet.

### Payment of Benefits to Others

When payments that should have been made under this Booklet were 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 Booklet, and with that payment We will fully satisfy Our liability under this provision.

### Duplicate Coverage and Coordination of Benefits 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 in whose behalf, the payments were made.

### Active Plan Termination

# TERMINATION/NONRENEWAL/CONTINUATION

Your coverage ends when one of the following happens:

* On the date the Employer Master Contract between the employer and Us ends.
* On the Subscriber’s death.
* When the Premium has not been paid.
* When you or your employer commits fraud or intentional misrepresentation of material fact.
* When you are no longer eligible under the terms of the Employer Master Contract.
* When your employer gives Us written notice that you are no longer eligible. Coverage will end on the date of the notice 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 notice to end coverage for any Member. Coverage will end at the end of the month following the notification period or at the end of the month of the qualifying event. We will credit Premium paid in advance unless We do not receive the cancellation request at least 31 days before the Effective Date of the cancellation.
* When you move and because of that move you no longer reside or work within the Service Area. The exception to this is if 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 terminated back to the date of the change of residence or place of employment. You will have to pay Us and/or the Providers for Our payment for any services covered in error.
* When We cease operations.

### Dependent Coverage Termination

To remove a Dependent from coverage, you must send Us the application 31 days before the Effective Date of the change. If We receive this 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 Premium paid in advance unless We do not get the application within 31 days before the Effective Date of the change or if We have paid any claims on behalf of the cancelled Dependent in the period for which the credit would 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. It may also end when one of the following happens:

* At the end of the month when you notify Us in writing to cancel coverage for a Dependent.
* When the Dependent no longer qualifies as a Dependent. Such a Dependent has the right to seek COBRA or state continuation coverage.
* On the date of a final divorce decree or legal separation for a spouse. Such a Dependent has the right to seek COBRA or state continuation coverage.
* If you are a partner to a civil union or other relationship recognized as a spousal relationship in the state where the Subscriber resides, on the date such union or relationship is revoked or terminated. Also, if there is coverage for designated beneficiaries, on the date a Recorded Designated Beneficiary Agreement is revoked or terminated. In either case, such a Dependent does not have the right to seek COBRA continuation coverage, but will be eligible for state continuation benefits, subject to the terms of this Booklet.
* At the end of the month when legal custody of a child placed for adoption ends.

### What We Will Pay for After Termination

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

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

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

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

# Continuation of Coverage

### Family and Medical Leave Act

When you take time off from work pursuant to the Family and Medical Leave Act, health insurance stays in force but you may be required to keep paying your share of the Premium. You may contact your employer for details.

### State Continuation Eligibility and Notification

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

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

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

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

### COBRA Eligibility and Notification

**COBRA Eligibility -** For employers with 20 or more employees, Subscribers and their Dependent who lose eligibility with a group may keep coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). You should call the employer for more details. COBRA coverage can last for 18, 29 or 36 months. The length of time you can have depends on the qualifying event(s) and only if the federal rules 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 ended or within 60 days after the coverage ended, due to one of the qualifying events above, and the employee or Dependent is still disabled when the 18-month continuation period ends.

COBRA coverage is available to Dependents for 36 months from the date of the following qualifying events for:

* The surviving spouse and surviving children of a covered employee, when the covered employee dies.
* Spouse and Dependents of a covered employee, when the employee becomes eligible for Medicare in the 18 months before the qualifying event.
* Spouse and Dependent children of a covered employee, when the employee and the Spouse separate or divorce.
* Dependent children of the covered employee, when they lose status 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 set the length of the continuation period for the newborn or adoptee.

**COBRA Notification -** Unless termination or reduction in hours is the qualifying event, a Subscriber, spouse, or Dependent child must tell the employer they want eligibility for COBRA coverage within 60 days of being eligible. Once the employer has given notice to the Subscriber, spouse and/or Dependent child of the right to get COBRA, We must get notice from them that you want COBRA coverage. We must also get payment of fees or Premiums for you to get on COBRA.

You have 60 days from the receipt of the employer notice or from the date the prior coverage would otherwise end, whichever is later, to tell the employer you want COBRA. To apply for COBRA, you must complete a COBRA or State Continuation of Coverage Application. The employer must complete their section, sign it, and send it to Us. After choosing COBRA, you must pay the first fees or Premiums due within 45 days. For more details, please call the employer.

### Termination of State Continuation Coverage or COBRA

Your continuation coverage ends when the continuation period ends. Continuation coverage may end before the continuation period ends if:

* The Employer Master Contract between Us and the employer ends. If the employer gets other group coverage, continuation coverage will continue under the new plan.
* You fail to pay Premium timely.
* Under state continuation coverage, you are eligible for another group health plan unless the other plan does not cover something that is covered by the continuation coverage. In that case, the state continuation coverage lasts until the continuation period ends or the other plan covers the excluded condition.
* Under state continuation coverage, the date the Recorded Designated Beneficiary Agreement is revoked or terminated, if it applies.
* Under COBRA coverage, you are covered by another group health plan unless the other coverage does not cover something that is covered by the COBRA coverage. In that case, the COBRA coverage lasts until the COBRA period ends or the other plan covers the excluded condition.
* The date the spouse remarries and becomes eligible for coverage under the new spouse’s group health plan.
* Under COBRA coverage, you get Medicare.
* Your COBRA coverage was extended to 29 months and you are determined under the Social Security Act to no longer be disabled.
* You tell Us in writing to cancel.

### Other Coverage Options Besides COBRA Continuation Coverage

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

# APPEALS AND COMPLAINTS

We want your experience with Us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your health benefit plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your Health Benefit ID card. We will try to resolve your complaint informally by talking to your Provider or reviewing your claim. If you are not satisfied with the resolution of the complaint, you have the right to file a complaint, appeal or grievance, which is defined below.

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

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

# Complaints

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

HMO Colorado Member Services Department

P.O. Box 17549 Denver, CO 80217-0549

If your complaint isn’t solved either by writing or calling, or if you don’t want to file a complaint, you can file an appeal. We’ll tell you how to do that next, in the Appeals section below.

# Appeals

If We have denied a claim that you feel should have been covered, or handled in a different way, or had your coverage cancelled retroactively for a reason that is not because of your failure to pay premiums, you can file an appeal. You can appeal a denial that was made by Us before the service is received. You can also appeal a denial on a service after it is received.

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

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

An appeal can be filed by writing to this address:

HMO Colorado

Attn: Grievance and Appeals Department 700 Broadway

Denver, CO 80273

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

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

### Internal Appeals

We have an internal process that We follow when reviewing your appeal. Members of Our staff, who were not involved when your claim was first denied, will review the appeal. They may also talk with co-workers to assist in the review.

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

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

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

### Independent External Appeals

For claims based on Utilization Review, you can request an independent external appeal. Utilization review includes claims We denied as Experimental or Investigational or not Medically Necessary. It also includes claims where We reviewed your medical circumstances to decide if an exclusion applied. For these appeals, your case is reviewed by an external review entity, selected by the Colorado Division of Insurance.

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

**Expedited external appeal** - You or your representative can request an expedited independent external review, but only in certain cases.

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

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

# Grievances

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

You may call member service or send a written grievance to:

HMO Colorado

Attn: Grievance and Appeals Department 700 Broadway

Denver, CO 80273-0001

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

# Division of Insurance Inquiries

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

# Binding Arbitration

The binding arbitration provision under this Booklet is applicable to claims arising under all individual plans, governmental plans, church plans, plans or claims to which ERISA preemption does not apply, and plans maintained outside the United States. Any such arbitration will be governed by the procedures and rules established by the American Arbitration Association. You may obtain a copy of the Rules of Arbitration by calling Our Member Services. The law of the state in which the plan 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.

# Legal Action

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

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

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

# Prescription Drug List Exceptions

Please refer to the “Prescription Drug List” section in “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for the process to submit an exception request for drugs not on the Prescription Drug list.

# INFORMATION ON PLAN AND RATE CHANGES

# Insurance Premiums

**How Premiums are Established and Changed -** Premiums are the monthly charges you and/or the employer must pay Us to get coverage. We figure out and set 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 have you 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 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 Booklet.

# DEFINITIONS

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

**Accidental Injuries** - unintentional injuries inside or outside your body, for example strains, animal bites, burns, contusions and abrasions which result in trauma. Accidental Injuries are different from beings sick.

**Acute Rehab Therapy** - Inpatient Rehab Therapy for a short period of time. Acute rehab therapy services are not the same as acute hospital medical or surgical care.

**Alcoholism Treatment Center** - a Hospital or Facility, licensed by the appropriate agency, providing services especially for the treatment of Alcohol and Substance Dependency.

**Alternative Care** - therapeutic practices that are not currently considered an integral part of conventional medical practice.

**Alternative Care Facility** - a health care Facility which is not a hospital, or an attached Facility assigned as free standing by a Hospital which mainly provides outpatient services such as:

* Diagnostic services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI).
* Surgery.
* Therapy services or rehab.

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

**Ambulatory Surgical Facility** - a Facility, with a staff of Doctors, that:

1. Is licensed as required.
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis.
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility.
4. Does not have Inpatient accommodations.
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

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

* General Anesthesia, also known as total body Anesthesia, puts you to sleep for a period of time.
* 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 your employer renews its coverage.

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

**Authorized Service(s)** - a Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will not have to pay any more than the In-Network Deductible, Coinsurance, and/or Copayment(s) that apply. Please see “Claims Procedure (How to File a Claim)” for more details.

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

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

**Autism Treatment Plan** - a plan for a Member by an Autism Services Provider and prescribed by a Doctor or psychologist in line with a evaluating or again reviewing a Member's diagnosis; proposed treatment by type, frequency, and expected

treatment; the expected outcomes stated as goals; and the rate by which the treatment plan will be updated. The treatment plan is in line with the patient-centered medical home as defined in applicable law.

**Benefit Period** - Your Benefit Period is based on a benefit year and begins on the Subscriber’s Effective Date, and end on the following June 30; a new Member’s Benefit Period starts on each July 1 that follows. If your coverage ends earlier, the Benefit Period ends at the same time.

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

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

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

**Booklet** - this book, sometimes called a Booklet, and any amendments or riders, which explains what is covered, what is not covered, and other terms of your health plan.

**Brand Name Drug** - Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

**Cardiac Rehab** - medically supervised program to resume your activities of daily living after a heart attack.

**Care Management** - a plan of Medically Necessary health care that best meets your needs.

**Centers of Excellence (COE) Network** - a network of health care facilities, which have been selected to give specific services to Our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with Us.

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

**Chronic Rehab Therapy** - a non-acute Inpatient Rehab Therapy that last for more than six months and may continue for a lifetime.

**Closed Panel Plan** - a health maintenance organization (HMO), preferred provider organization (PPO) or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly, indirectly, or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel provider.

**COBRA** - stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law allows people to continue their insurance for a period of time after ending a job or due to a qualifying event.

**Coinsurance** - percentage of costs you share with Us.

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

**Coordination of Benefits** - it is where an insurance plan prevents duplicate payments for services covered by more than one insurance plan. For example, you may be covered by your own plan, as well as a spouse's plan. Medical costs are covered first by the person's own plan. Any balance is submitted to the spouse's insurance plan for additional review or payment.

**Copayment** - is a fixed amount you must pay out of your own pocket for service by a Provider.

**Cosmetic** - services to keep, change or improve your appearance or are done for mental reasons.

**Cost Sharing** - the term used for out-of-pocket costs you pay, for example Copayments and Coinsurance paid by you.

**Covered Services -** services, supplies or treatments which are:

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

**Creditable Coverage** - health coverage that you had within 90 days before coverage with Us under this Booklet. A creditable health coverage includes Medicare or Medicaid coverage, a group or individual health coverage, state high risk pool coverage, any federal or state health coverage or any other health coverage that gives basic medical and Hospital care.

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

**Dependent** - a Subscriber’s legal spouse, common-law spouse, designated beneficiary, partner to a civil union, or child as defined in the “Eligibility” section of this Booklet.

**Doctor** - see the definition of “Provider.”

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

**Early Intervention Services** - Services, as defined by Law in accordance with Part C, that are authorized through an Eligible Child's IFSP but that exclude: nonemergency medical transportation; respite care; service coordination, as defined in federal law; and assistive technology (unless covered under this Booklet as durable medical equipment).

* Eligible Child - means an infant or toddler, from birth through two years of age, who is an eligible Dependent and who, as defined by Law, has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for services pursuant to Law.
* Individualized family service plan or IFSP - means a written plan developed pursuant to federal law that authorizes early intervention services to an Eligible Child and the child's family. An IFSP shall serve as the individualized plan for an Eligible Child from birth through two years of age.

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

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

**Employer/Group** - The employer or other organization (e.g., association), which has a Employer Master Contract with us, Anthem Blue Cross and Blue Shield for this Plan.

**Employer Master Contract** - the agreement between Us and your employer stating all of the terms that applies to group coverage. The final interpretation of any terms found in this Booklet is governed by the Employer Master Contract.

### Experimental or Investigational -

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

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

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

* Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted.
* Has been determined by the FDA to be contraindicated for the specific use.
* Is provided as part of a clinical research protocol or clinical trial (except as noted in the Clinical Trials section under Covered Services in this Booklet as required by applicable 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.

1. 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.

1. 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.

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

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

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

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

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

**Health Benefit ID Card** - the card We give you with information such your name and ID number for this plan.

**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 Booklet as “Us”, “We”, or “Our.” Also referred to as "HMOC".

**Home Health Care Agency** - A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home.
2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

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

**Hospice** - a Provider that gives care to terminally ill patients and their families, either directly or on a consulting basis with the patient’s Doctor. It must be licensed by the appropriate agency.

**Hospital** - a Provider licensed and operated as required by law, which has:

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

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

1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse

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

**Inpatient Rehab 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 Rehab Therapy may be received from an acute rehabilitation Facility, Skilled Nursing Facility, long term acute care Facility or sub-acute Facility. Inpatient Rehab Therapy includes acute rehabilitation therapy, chronic rehabilitation therapy or sub-acute rehabilitation therapy.\

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

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

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

**Maintenance Medications** - please see the “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” section for details.

**Maintenance Pharmacy** - an In-Network Retail Pharmacy that is contracted with Our PBM to dispense a 90 day supply of Maintenance Medication.

**Maximum Allowed Amount** - the maximum amount that We will allow for Covered Services that you receive. More details can be found in the “How to Access Your Services and Obtain Approval of Benefits” section of this Booklet.

**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.

**Medically Necessary** - the diagnosis, evaluation and treatment of a condition, illness, disease or injury that We solely decide to be:

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

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

**Medical Plan and Technology Assessment** - a process We use to review and evaluate new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the experimental / investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem’s medical plan is provided by the Medical Plan and Technology Assessment Committee (MPTAC) which consists of approximately 20 doctors from various medical specialties including Our medical directors, doctors in academic medicine and doctors in private practice.

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

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

**Member** - the Subscriber or any Dependent who is enrolled for coverage under this Booklet. Also referred to in this Booklet as “you” or “your”.

**Mental Health and Substance Abuse** - a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition. Coverage is also provided for Biologically Based Mental Illness for schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

**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.

**Out-of-Network** - a term for Providers that do not enter into a network contract with Us. Services received from an Out-of- Network Provider are not available unless they are for Emergency Care, urgent care, or for services approved in advance by Us as an authorized service.

**Out-of-Pocket Annual Maximum** - the Cost Sharing total that you may be responsible for under this Booklet for most medical and prescription costs. Benefit Period maximums or lifetime maximums under this Booklet will still apply, even if you have satisfied your Out-of-Pocket Annual Maximum.

**Partial Hospitalization Program** - structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

**Pharmacy** - a place licensed by applicable law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Provider.

**Pharmacy and Therapeutics (P&T) Process** - a process to make clinically based recommendations that will help you access quality, low cost medicines within your plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for Our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, precertification criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

**Precertification** - 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 Drug (Drug) (also referred to as Legend Drug)** - a medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1. Compounded (combination) medications, when all of the ingredients are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
2. Insulin, diabetic supplies, and syringes.

**Provider** - a person or Facility that is recognized by Us as a health care Provider and fits one or more of these descriptions:

**Doctor** - A doctor of medicine or osteopathy who is licensed to practice medicine under the laws of the state or jurisdiction where care is given.

**Professional Provider** - a Doctor or other professional Provider who is licensed by the state or jurisdiction where Covered Services are provided for benefits to be payable. Such services are subject to review by a medical authority appointed by Us.

**Facility Provider (Facility)** - A Facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable or meet specific rules set by Us.

**Mid-Level Provider** - are registered nurses, clinical nurse specialists, nurse practitioners, physicians assistants or as determined by Us. Mid-Level Providers may not be selected as a PCP. We may assign the PCP Copayment to Covered Services of a Mid-Level Provider.

**Primary Care Provider** (PCP - is typically an internal medicine Doctor, family practice Doctor, general practitioner, pediatrician, advanced nurse practitioner, or advanced registered nurse practitioner who has contracted with Us to supervise, coordinate and provide initial and basic care.

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

* + Psychiatrist.
  + Orthopedist.
  + Obstetrician.
  + Gynecologist.
  + Cardiologist

**Retail Health Clinic Provider** - a facility that gives you limited basic medical care on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically given by Doctor assistants and nurse practitioners.

**Qualified Early Intervention Service Provider** - means a person or agency, as defined by Law in accordance with Part C, who provides Early Intervention Services and is listed on the registry of early intervention service Providers.

**Reconstructive Surgery** - includes procedures that are meant to address a major change from normal in relation to accidental injury, disease, trauma, treatment of a disease or Congenital Defect.

**Recorded Designated Beneficiary Agreement** - an agreement entered into by two people for the purpose of making each a beneficiary of the other and which has been recorded with the county clerk and recorder in the county in which one of the person lives. The agreement is based on the Colorado Designated Beneficiary Act.

**Residential Treatment/Facility** - a Provider licensed and operated as required by law, which includes:

1. Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability.
2. A staff with one or more Doctors available at all times.
3. Residential treatment takes place in a structured Facility-based setting.
4. The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
5. Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.
6. Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

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

1. Nursing care.
2. Rest care.
3. Convalescent care.
4. Care of the aged.
5. Custodial Care.
6. Educational care.

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

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

1. Inpatient care and treatment for people who are recovering from an illness or injury.
2. Care supervised by a Doctor.
3. 24 hour per day nursing care supervised by a full-time registered nurse.

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

**Specialty Drugs** - Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at a Retail Pharmacy. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

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

**Step Therapy** - process that first requires the use of designated drug over others for treatment as supported by clinical practice guidelines.

**Sub-Acute Rehab Therapy** - care that includes a minimum of one hour of therapy when you can no longer tolerate, but it does not require three hours of therapy a day. This type of rehab is normally done in a Skilled Nursing Facility.

**Subcontractor** - We may subcontract particular services to organizations that are experts in certain areas. This may include services for Prescription Drugs, Mental Health and Substance Abuse. Such organizations may make decide on benefits or perform administrative, claims paying, or Member Services duties on Our behalf.

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

**Substance Dependency** - a condition which you use alcohol, drugs and other substances in a manner that damages your health or loses your ability to control your actions.

**Surgery** - any variety of technical procedures for treatment or diagnosis of anatomical disease or injury, such as cutting, micro Surgery (use of scopes), laser procedures, grafting, suturing, castings, treatment of fractures and dislocations, electrical, chemical or medical destruction of tissue, endoscopic examinations, anesthetic epidural procedures, and other invasive procedures. Covered surgical services also include Anesthesia and pre- and post-operative care, including recasting.

**Telemedicine** - is used to support health care when you and the Doctor are physically separated. Typically, you communicate through an interactive mean that is enough to start a link to the Provider who is working at a different location from you.

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

**Transplant Benefit Period** - the Transplant Benefit Period starts one day prior to a covered transplant procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network transplant Provider agreement.

**Urgent Care** - is not an Emergency, but an unexpected illness or injury requiring treatment that cannot reasonably be postponed for regularly scheduled care.

**Urgent Care Center** - a licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

**Utilization Review -** evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section “Prescription Drugs Administered by a Medical Provider"), procedures, and/or facilities.

### End of Booklet

**Get help in your language**

**Curious to know what all this says? We would be too. Here’s the English version:**

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

### Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda**. (TTY/TDD: 711)**

### Amharic

ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

### Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجا ًنا. اتصل برقم خدمات األعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة

.)TTY/TDD:711(

### Bassa

M̀ ɓéɖé dyí-ɓɛ̀ɖɛ̀ìn-ɖɛ̀ɔ̀ ɓɛ́ m̀ ké bɔ̃̌ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Ɖá mɛ́ɓà jè gbo-gmɔ Kpòɛ̀ nɔ̀ ɓà nìà nì Dyí-dyoìn-bɛ̀ɔ kɔ ɛ ɓɛ́ m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

### Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

### Farsi

شما اين حق را داريد که اين اطالعات و کمکها را به صورت رايگان به زبان خودتان دريافت کنيد. برای دريافت کمک به شماره مرکز خدمات اعضاء که بر

روی کارت شناسايیتان درج شده است، تماس بگيريد711). (TTY/TDD:

### French

Vous avez le droit d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d’identification. (TTY/TDD: 711)

### German

Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

### Igbo

Ị nwere ikike ịnweta ozi a yana enyemaka n’asụsụ gị n’efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

### Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

### Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

### Nepali

तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा ननिःशुल्क प्राप्त गने तपाईंको अधिकार हो। सहायताको लाधग तपाईंको ID कार्मा

दिइएको सिस्य सेवा नम्बरमा कल गनुहोस।् (TTY/TDD: 711)

### Oromo

Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

### Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

### Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

### Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

### Yoruba

O ní ẹ̀ tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́ fẹ̀ ẹ́ . Pe Nọ́ mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́ . (TTY/TDD: 711)

### It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to [compliance.coordinatorhem.com.](mailto:compliance.coordinator@anthem.com) Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>