



Health Plan

EXCLUSIVE

A Guide to Your Benefits

University of Colorado Health and Welfare Plan

Funded by the University of Colorado Health and Welfare Trust

Welcome

Welcome to Your CU Health Plan, provided by the University of Colorado Health and Welfare Trust ("Plan"), where it's our mission is to mitigate the rising costs of healthcare, tailor health plans to specific needs of employees, retirees and their dependents based on data and evidence-based approaches, and emphasize a commitment to wellness. You have enrolled in a quality self-funded health benefit Plan that, pursuant to the terms of this Booklet, pays for many of your health care expenses, including most expenses for physician and outpatient care, emergency care and hospital inpatient care.

Anthem Blue Cross and Blue Shield/HMO Colorado (Anthem) provides administrative claims payment services only, including but not limited to provider network contracting, Member Services, pharmacy benefits management, and care management. Throughout this Booklet "Our", "We" and "Us" refer to Anthem Blue Cross and Blue Shield/HMO Colorado (Anthem) or CU Health Plan.

Important: This is not an insured benefit plan. *The benefits described in this Booklet or any rider or amendments hereto are funded by the employers and subscribers. The benefits are paid from the University of Colorado Health and Welfare Trust. Anthem Blue Cross and Blue Shield/HMO Colorado (Anthem) provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.*

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

For questions about coverage or how benefits are administered, please visit the CU Health Plan website or call Anthem Blue Cross and Blue Shield/HMO Colorado (Anthem) Member Services department. The website address and toll-free Member Services department number are located on your Health Benefit ID Card.

Thank you for selecting this CU Health Plan. We wish you good health.



Tony DeCrosta
Chief Plan Administrator
University of Colorado Health and Welfare Trust



Mike Ramseier
President and General Manager
Anthem Blue Cross and Blue Shield
HMO Colorado

Acceptance of coverage under this Booklet constitutes acceptance of 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 Coverage* and any amendments or endorsements thereto;
- The Benefits Enrollment/Change Form or online application available from your employer and any other application required by the employer for the Subscriber and the Subscriber's Dependents; and
- Your Health Benefit ID Card.

In addition, the following important documents are part of the terms of your health benefits coverage:

- The University of Colorado Health and Welfare Trust ("Trust") Plan Documents;
- The Administrative Services Agreement among Us, the Trust Committee, on behalf of the Trust, and The Regents of the University of Colorado, a body corporate and a state institution of higher education of the State of Colorado ("Plan Sponsor"); and
- The Plan Document and Summary Plan Description for the University of Colorado Health and Welfare Trust.

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

This Booklet is neither an insurance policy nor a Medicare Supplement insurance policy. If you are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Anthem Blue Cross and Blue Shield/HMO Colorado. Contact Our Member Services department for information on how to obtain this guide. Please contact your employer to discuss coverage options that are available through your employer.

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Anthem Blue Cross and Blue Shield/HMO Colorado is an independent licensee of the Blue Cross Association (BCA).

TABLE OF CONTENTS

YOUR RIGHTS AND RESPONSIBILITIES	7
ABOUT YOUR HEALTH BENEFITS.....	9
PRIMARY CARE PROVIDERS	9
<i>Selecting A PCP</i>	<i>9</i>
<i>Visiting A PCP</i>	<i>10</i>
<i>Changing PCPs</i>	<i>10</i>
<i>Referrals</i>	<i>10</i>
CARE OUTSIDE OF COLORADO.....	11
WHAT IS THE A WAY FROM HOME CARE PROGRAM?.....	11
WHERE IS GUEST MEMBERSHIP AVAILABLE?.....	11
POINTS TO REMEMBER:.....	11
PARTICIPATING STATES:.....	12
COST SHARING REQUIREMENTS	13
<i>Maximum Allowed Amount.....</i>	<i>13</i>
<i>Provider Network Status</i>	<i>13</i>
<i>Member Cost Share.....</i>	<i>14</i>
<i>Authorized Services.....</i>	<i>14</i>
<i>Claims Review</i>	<i>14</i>
<i>Deductible.....</i>	<i>14</i>
<i>Out-of-Pocket Annual Maximum.....</i>	<i>15</i>
MANAGED CARE FEATURES.....	16
<i>Transition of Care.....</i>	<i>16</i>
<i>Our Process to Determine If Services are Covered.....</i>	<i>16</i>
<i>Appropriate Place and Preauthorization.....</i>	<i>17</i>
<i>Appropriate Length of Stay.....</i>	<i>19</i>
<i>Ongoing Care Needs</i>	<i>19</i>
THE BLUECARD PROGRAM.....	21
MEMBERSHIP.....	22
SUBSCRIBER.....	22
DEPENDENTS	22
MEDICARE-ELIGIBLE MEMBERS.....	23
ENROLLMENT PROCESS	23
HOW TO CHANGE COVERAGE	26
TERMINATION	26
CONTINUATION OF BENEFITS	27
COVERED SERVICES.....	32
PREVENTIVE CARE SERVICES	32
INFERTILITY SERVICES.....	34
MATERNITY SERVICES AND NEWBORN CARE	34
DIABETES MANAGEMENT SERVICES	35
PHYSICIAN OFFICE SERVICES	35
INPATIENT SERVICES	35
INPATIENT REHAB SERVICES.....	36
OUTPATIENT SERVICES.....	37
DIAGNOSTIC SERVICES	37
SURGICAL SERVICES	37
EMERGENCY CARE AND URGENT CARE	38
AMBULANCE AND TRANSPORTATION SERVICES.....	39
THERAPY SERVICES	40
AUTISM SERVICES.....	41
CHIROPRACTIC AND ACUPUNCTURE THERAPY	41
PHYSICAL MEDICINE AND REHABILITATION SERVICES.....	41
HOME CARE/HOME IV THERAPY SERVICES	42
NUTRITIONAL COUNSELING	42

MEDICAL FOODS	42
HOSPICE CARE SERVICES	43
HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES	43
MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES	45
HEARING AID SERVICES	46
DENTAL RELATED SERVICES	47
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	48
PRESCRIPTION DRUGS ADMINISTERED BY A MEDICAL PROVIDER	48
RETAIL PHARMACY/MAIL ORDER PRESCRIPTION DRUGS	49
CLINICAL TRIALS	52
GENERAL EXCLUSIONS	54
ADMINISTRATIVE INFORMATION	60
PREMIUMS	60
HOW TO FILE CLAIMS	60
GENERAL PROVISIONS	62
WORKERS' COMPENSATION	64
AUTOMOBILE INSURANCE PROVISIONS	64
THIRD PARTY LIABILITY: SUBROGATION AND RIGHT OF REIMBURSEMENT	65
DUPLICATE COVERAGE AND COORDINATION OF BENEFITS	66
COMPLAINTS, APPEALS AND GRIEVANCES	71
COMPLAINTS	71
APPEALS	71
GRIEVANCES	74
LEGAL ACTION	74
GLOSSARY	75

YOUR RIGHTS AND RESPONSIBILITIES

As a Member of this CU Health Plan administered by Anthem Blue Cross and Blue Shield/HMO Colorado you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your Doctors. It's kind of like a "Bill of Rights." And it helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our network Providers and the information you need to make the best decisions for your health and welfare.

You have the right to:

- Speak freely and privately with your health care Providers about all health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your plan.
- Work with your Doctors to make choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private by following Our privacy policies, and state and Federal laws.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
 - Our company and services.
 - Our network of health care Providers.
 - Your rights and responsibilities.
 - The rules of your health plan.
 - The way your health plan works.
- Make a complaint or file an appeal about:
 - Your health plan and any care you receive.
 - Any Covered Service or benefit decision that your health plan makes.
- Say no to care, for any condition, sickness or disease, without 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 all of the most up-to-date information from a Doctor or other health care Provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand to the best of your ability all information about your health benefits and ask for help if you need it.
- Follow all plan rules and policies.
- Choose an In-Network Primary Care Provider (Doctor or other provider recognized by Us as a Primary Care Provider), also called a PCP.
- Treat all Doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care Providers. Call their 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.

- Let your employer and our Member Services department know if you have any changes to your name, address or family members covered under your plan.
- 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.

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, you can file a grievance as explained in this Booklet. And if you have any concerns or suggestions on how we can improve Our overall operations and service, We encourage you to contact Member Services.

If you need more information or would like to contact Us, please go to www.anthem.com/CUHealthPlan and select Customer Support under Important Links or call the Member Services number on your Health Benefit ID Card.

How to Obtain Language Assistance

We are committed to communicating with Our members about their health plan, regardless of their language. We employ a Language Line interpretation service for use by all of Our Member Services Call Centers. Simply call the Member Services phone number on the back of your Health Benefit ID Card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Member Services.

ABOUT YOUR HEALTH BENEFITS

This is a client specific HMO health benefit plan. We have coordinated and contracted through the CU Health Plan-Exclusive North, CU Health Plan-Exclusive Central and CU Health Plan-Exclusive South network (collectively the CU Health Plan-Exclusive network) of Professional Providers, Hospitals, pharmacies, and support services (e.g., laboratory, x-ray, pharmacy, and physical therapy) to arrange for or provide comprehensive health care services to Members. Learning how an HMO works can help you make the best use of your health care benefits. Provider can be accessed through the Find a Provider link at www.anthem.com/CUHealthPlan.

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

Primary Care Providers

A key feature of this Plan is that one Professional Provider will be primarily responsible for delivering and coordinating all of your care. That Professional Provider is called a Primary Care Provider (PCP). PCPs are typically internal medicine Providers, family practice Providers, general practitioners pediatricians, advanced nurse practitioner or advanced registered nurse practitioners and other providers licensed in the state where they practice and recognized by Us as PCPs. As your first point of contact, the PCP provides a wide range of health care services, including initial diagnosis and treatment, health supervision, management of chronic conditions, preventive care, and Referrals to Specialists when appropriate.

A Referral service is any Covered Service that cannot be performed by your PCP and for which the PCP has given you a Referral to any other Provider, usually a Specialist. However, if the Referral service requires Preauthorization before it can be performed, the approval of a Referral alone does not guarantee or imply coverage for the services or procedures to be performed by the Specialist.

You can access care from certain In-Network Providers without a Referral. Members do not need a Referral from their PCP to access the services of an OB/GYN Provider, ophthalmologists, acupuncturist or chiropractor; you may self-refer to In-Network OB/GYN Providers for obstetrical and gynecological services, to an ophthalmologist for medical eye care and to a chiropractor for chiropractic care. These self-referral services will only be covered when services are received from an OB/GYN Provider, ophthalmologist, or chiropractor in the Exclusive plan network. We or your PCP can provide you Referrals and information about Specialists who are In-Network.

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

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

When you visit an In-Network Provider that In-Network Provider will bill Us directly and accept Our Maximum Allowed Amount as payment in full. The Maximum Allowed Amount is described in the **COST SHARING REQUIREMENTS** section of this Benefits Booklet.

Selecting A PCP

At the time of enrollment, you must select a PCP. You have the right to designate any PCP who participates in the CU Health Plan-Exclusive and who is available to accept you or your family members. Family members are not required to choose the same PCP; they may select a PCP individually. If a PCP is not chosen, We will assign one to the Member. For a child, you may designate a pediatrician as the child's PCP.

To locate a PCP, you may call the Member Services number that is listed on your Health Benefit ID Card. You may also search for a PCP or Hospital on-line at www.anthem.com/CUHealthPlan by selecting the Find a Provider link. Our website is continuously updated and is the most up-to-date list of Our PCPs. Some Providers are listed as accepting existing patients only. However, We may not have notice of new limitations of this kind. Therefore, even if the listing for the PCP you select does not indicate patient limitations, you should call the PCP to confirm that the Provider is still accepting new patients (unless you are already an existing patient of the PCP).

Visiting A PCP

To visit a PCP, you must make an appointment with the PCP's office. The telephone number for your 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 a CU Health Plan-Exclusive Member. The PCP's office will instruct you on next steps in non-Emergency Care or non-Urgent Care situations.

You should notify your PCP's office at least 24 hours before a scheduled appointment if you need to cancel an appointment. You should check with your PCP to determine how far in advance a cancellation must be received. You may be charged a fee by your PCP's office for a missed appointment. We will not pay for or reimburse you for such a fee. You should notify the PCP's office if 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 addressing your needs. You should call your PCP for instructions on how to receive medical care after the PCP's normal business hours, on weekends and holidays, or to receive non-Emergency Care and non-Urgent Care within the Service Area for a condition that is not life threatening but that requires prompt medical attention. In case of an Emergency, you should call 911 or go directly to the nearest Emergency room.

Changing PCPs

You may select a new PCP at any time. A change may also be made if you change primary residence or place of employment to a location that is not convenient to your current PCP's office. You may choose a new PCP nearer to your new residence or place of employment, within Our Service Area. PCP changes may only be made once per month by calling Our Member Services department. You should call the PCP to confirm that the Provider is accepting new patients. A new Health Benefit ID Card will be sent to you confirming the PCP change.

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

Any Referrals provided by your previous PCP must be reviewed by the new PCP. New Referrals must be issued by the new PCP before Referral care will be covered.

Referrals

A PCP provides you with basic health and medical services including routine and preventive care. Sometimes it is necessary to visit a Specialist or other Provider. You must first obtain a Referral from the PCP when you want or need to visit a Provider or health care Provider other than your PCP. Your PCP will recommend and coordinate any care provided by other health care Providers. This is accomplished through a Referral. A Referral is the formal recommendation by a Provider for you to receive care from a Specialist or a different Provider or facility. The PCP will submit a Referral request to the CU Health Plan-Exclusive Network for recommendation by phone or fax. Your PCP will be notified of approval or denial of the Referral request. All Referrals must be obtained before receiving services. Retroactive Referrals are not available.

You do not need a Referral from the PCP for:

- An Emergency or Urgent situations;
- Care from an In-Network OB/GYN Provider or certified nurse midwife for obstetric or gynecologic care;
- Care from an In-Network ophthalmologists for medical eye care; or
- Chiropractic services.

If you visit any other Provider – including a CU Health Plan-Exclusive In-Network provider – without a Referral, you will be responsible for all charges except as provided above.

Referrals can be made for a certain number of visits to Specialists and a specific time period in which you must receive the care. You should not make a second appointment with a Specialist if only one visit is authorized. You are responsible for all charges related to visits in excess of those authorized. If a Referral is **not** obtained for nonemergency in-network care (except as provided above), the CU Health Plan-Exclusive will **not** cover those services.

Care Outside of Colorado

When you are outside Our Service Area benefits are only available for Emergency or Urgent Care or for a dependent child enrolled in the Away From Home Care (also known as Guest Membership program).

Away From Home Care (Guest Membership Program)

- **Available ONLY for covered children who reside outside Colorado and who are enrolled in CU Health Plan-Exclusive.**
- **NOT AVAILABLE FOR EMPLOYEES OR SPOUSES/PARTNERS/SGDPs**

WHAT IS THE AWAY FROM HOME CARE PROGRAM?

The Away From Home Care Program provides Guest Membership if your covered child will be outside of the CU Health Plan-Exclusive Service Area for at least 90 days in one location.

Guest Membership allows your covered child to join another Blue Cross Blue Shield Plan and receive the full range of benefits offered by that Plan, excluding any “riders” you may have, i.e. prescription drugs, chiropractic care, or dental care. Review the provider directory at www.anthem.com/CUHealthPlan to find pharmacy locations and how to enroll in the University of Colorado Hospital Mail Order Prescription service. **Prescription drug coverage will be provided exactly as it works for any CU Health Plan-Exclusive member.**

You won't have to complete a claim form or pay up front for your child's health care services, except for the out-of-pocket expenses (non-covered expenses, copayments and coinsurance) that you would normally pay anyway. (Please note that these payments might be different from those required by your home plan).

WHERE IS GUEST MEMBERSHIP AVAILABLE?

Membership is available if there is a participating Plan in your child's location (“Host Plan”). If it happens that the area your child will be in does not have a participating Plan, the Guest Membership would not be an option. See the following page for current states that participate. It is also important to note that even if the state is covered within the Guest Membership program, the county in which your child lives may not be covered.

The name of the City, County and State away from home will help us locate a Host Plan. Reasons for Guest Membership may include students away at school, the child(ren) of families living apart, and child's long-term travel. Students away at school and child(ren) of families living apart can have up to one year for Guest Membership. Renewals **must be requested by you before the end of your child's Guest Membership.**

POINTS TO REMEMBER:

- It usually takes 30 days from the date of the request to establish a Guest Membership in a Host Plan. Membership becomes effective **15 days after receipt of the signed application.**
- Please call 800-827-6422 to request an application. The application is also available at www.anthem.com/CUHealthPlan. You will need to know the “away from home” address including zip code. If a Guest Member is a minor, you will need to supply the name of the person caring for them in the Host Plan.
- The application will be sent to you, the Subscriber, for signature and completion of the application.
- The Host Plan will contact the Guest Member to select a PCP and issue a Health Benefit ID Card and enter the membership in their system.
- Guest Membership always includes an expiration date.
- Eligible Guest Memberships must be renewed each year. **Student certification through the home plan does not automatically renew a Guest Membership.**
- **Guest Membership Renewal letters will be sent 45 days prior to the expiration date.**
- Urgent Care is available while your child is waiting for Guest Membership to become effective. Call your CU Health Plan-Exclusive Member Services at the number on the back of your Health Benefit ID Card or call the Provider Locator at 800-810-2583.
- The enrolled child **MUST** use their GUEST Health Benefit ID Card when away from home and their CU Health Plan-Exclusive card when in Colorado.

PARTICIPATING STATES:

(SUBJECT TO CHANGE)

- Arizona
- Arkansas
- California
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Illinois
- Indiana
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Missouri
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- Ohio
- Pennsylvania
- Rhode Island
- South Carolina
- Texas
- Virginia
- Wisconsin

COST SHARING REQUIREMENTS

Cost Sharing refers to how the University of Colorado Health and Welfare Trust shares the cost of health care services with you. It defines what We are responsible for paying on behalf of the Trust and what you are responsible for paying. You meet your Cost Sharing requirements through the payment of Deductible, Coinsurance and/or Copayments (as described below).

Cost Sharing requirements depend on the choices you make in accessing services. Your Cost Sharing requirements are based on the Maximum Allowed Amount and described in the *Summary of Benefits and Coverage*.

We work with Physicians, 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 Us discounts. 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 In-Network Providers include a "hold harmless" clause which provides that you cannot be responsible to the In-Network Provider for claims owed by the Trust for health care services covered under this Booklet.

You are always liable for a Provider's full Billed Charges for any non-Covered Service and Services that exceed the Benefit Period Maximum.

Maximum Allowed Amount

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

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

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

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

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 received were not Medically Necessary. It means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

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

Provider Network Status

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 to the extent you have not met your Deductible or have Coinsurance. Please call Member Services for help in finding a Participating Provider or visit www.anthem.com/CUHealthPlan.

Member Cost Share

For certain Covered Services, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Coinsurance and/or Copayments). Please see the *Summary of Benefits and Coverage* for your cost share amounts and limitations.

We, on behalf of the Trust, will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by the Provider for non-Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. 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 benefit caps or day/visit limits.

In some instances you may only be asked to pay the In-Network cost sharing amount when you use a Non-Participating Provider. For example, if you go to an In-Network/Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the In-Network cost share amounts for those Covered Services, and you will not be required to pay more for the services than if the services had been received from a Participating Provider.

Under certain circumstances, if We, on behalf of the Plan, pay the Provider amounts that are your responsibility, such as Deductible, Coinsurance and/or Copayments, We may collect such amounts directly 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 and non-Urgent 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, on behalf of the Trust, may authorize the In-Network Cost Sharing amounts (Deductible, Coinsurance and/or Copayments) 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.

When preauthorized or for Emergency or Urgent Care, Copayments for Covered Services received from an Out-of-Network Provider are the same as the Copayments for Covered Services received from an In Network Provider

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.

Copayment

Copayment amounts are listed in the *Summary of Benefits and Coverage*.

A Copayment is a predetermined, fixed-dollar amount you must pay to receive a specific Covered Service. You are required to pay a Copayment to In-Network Providers for specific Covered Services. You are responsible for making Copayments directly to the In-Network Provider. Your copayment may be higher for a Specialist than for a Primary Care Provider. You must pay fixed-dollar Copayment amounts even after meeting Deductible and/or Coinsurance. Copayment amounts do not apply to Deductible and/or Coinsurance requirements.

In addition to any Copayment required, you are responsible for any applicable Deductible and/or Coinsurance for additional services received, e.g., laboratory and x-ray services.

Deductible

The Deductible amount is listed in the *Summary of Benefits and Coverage*.

A Deductible is a specified dollar amount for Covered Services that you must pay within your Benefit Period before We authorize payment for benefits. Copayments and Coinsurance are separate from and do not apply to the Deductible. On some Covered Services the Deductible may be waived. The deductibles contribute toward your Out-of-Pocket Annual Maximum. If a service is subject to a Copayment, that service may not be subject to the Deductible. A new Deductible is required for each Benefit Period.

Single Deductible - Under a Single Membership (coverage of only one person), You have to meet the Deductible as an individual Member.

Family Deductible - Under a Family Membership for Covered Services, the family Deductible amount is met as follows: when one family Member has satisfied their individual Deductible, that family Member is eligible for benefits. The enrolled remaining family Members are eligible for benefits when they individually satisfy their individual Deductibles or collectively satisfy the balance of the family Deductible. One family Member may not contribute any more than the individual Deductible towards the family Deductible. When no family Member meets their individual Deductible, but the family Members collectively meet the entire family Deductible, then all family Members will be eligible for benefits.

The Family Deductible is also applicable for newborn and adopted children (and for all other Members) for the first 31-day period following birth or adoption if the child is enrolled or not enrolled. Even if the child is not enrolled during the 31-day period, the Family Deductible will apply during that 31-day period.

Out-of-Pocket Annual Maximum

The Out-of-Pocket Annual Maximum amount is listed in the *Summary of Benefits and Coverage*.

Out-of-Pocket Annual Maximum is designed to protect you from catastrophic health care costs. Deductibles, Coinsurance and Copayments are included in the Out-of-Pocket Annual Maximum. Once you and/or your family have satisfied the Out-of-Pocket Annual Maximum, no additional, Deductible, Coinsurance and/or Copayments will be required for you and/or your family for the rest of the Benefit Period. The Out-of-Pocket Annual maximum is found on the *Summary of Benefits and Coverage*.

Single Out-of-Pocket Annual Maximum - Under a Single Membership (coverage of only one person), You have to meet the Out-of-Pocket Annual Maximum as an individual Member.

Family Out-of-Pocket Annual Maximum - Under a Family Membership for Covered Services, 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, that family Member will be treated as having satisfied the Out-of-Pocket Annual Maximum. The enrolled remaining family Members are must individually satisfy their individual Out-of-Pocket Annual Maximum or collectively satisfy the balance of the family Out-of-Pocket Annual Maximum. One family Member may not contribute any more than the individual Out-of-Pocket Annual Maximum towards the family Out-of-Pocket Annual Maximum. When no family Member meets their individual Out-of-Pocket Annual Maximum, but the family Members collectively meet the entire family Deductible, then all family Members will be treated as having satisfied the Out-of-Pocket Annual Maximum.

Note: A member 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.

Benefit Period Maximum

Benefit Period Maximums are listed in the *Summary of Benefits and Coverage*.

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

MANAGED CARE FEATURES

Managed Care is a system of health care delivery with the goal of giving you access to quality, cost effective health care while optimizing utilization and cost of services, and measuring In-Network Provider and coverage performance. We use a variety of administrative processes and tools, such as Preauthorization for health care services, Care Management, concurrent Hospital review and Disease Management to help determine the most appropriate use of the health care services available to Our Members. Your health benefit plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting may not be Medically Necessary if they are performed in a higher cost setting. This section of the Booklet explains how these Managed Care features are used and will guide you through the necessary steps to obtain care. For more information about how you should proceed in case of Emergency care and Urgent care, please see the **COVERED SERVICES** section of this Booklet.

We may subcontract particular administrative processes to organizations or entities that have specialized expertise in certain areas such as Disease Management. To determine which services require Preauthorization and/or to be sure that Preauthorization has been obtained, you may contact Member Services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims payment or Member Services duties on Our behalf.

Due to the unique arrangement of this CU Health Plan-Exclusive network we have subcontracted with University Physicians, Inc. (UPI) for Preauthorization of certain services. The In-Network Provider who schedules an admission or orders the procedures or service is responsible for obtaining Preauthorization and for knowing who to contact for Preauthorization.

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

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

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

You may determine whether a Provider is Participating in certain programs by checking your Provider directory or contacting Member Services at the 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 benefit plan's members.

You are free to choose your Hospital and Doctors and other healthcare Providers. But not all Providers are covered under this Booklet. We require that Providers hold valid licenses, practice within the scope of their license and be a member of or acceptable to the attending staff and board of directors of the Hospital in which the services are to be provided.

Transition of Care

A new Member to this coverage may be receiving ongoing care for a medical condition. Examples of ongoing care include prenatal/obstetrical care, Home Care or Hospice Care. We strive to avoid disruption of a new Member's care through Our transition of care policy. To facilitate the transition of care, you or your provider need to use the Continuity of Care form that is available by going to www.anthem.com/CUHealthPlan. Once completed, you will need to submit it to Us for review. You or your Provider may also request the Continuity of Care form by calling the Member Services number on your Health Benefit ID Card.

Our Process to Determine If Services are Covered

In administering this Plan and determining whether a health service is a covered benefit, We consider whether the service is Medically Necessary and whether the service is Experimental/Investigational, cosmetic or otherwise excluded under this Booklet. We also consider if the terms of this Booklet limit or deny benefits for the service. We use many resources, like:

- Peer-reviewed medical literature (such as publications and journals);
- Our adopted medical policies and practice guidelines;
- Guidelines or professional standards which we get from national organizations and professional groups; and
- Consultations with Doctors, Specialists and other health care Providers.

We will decide what services are covered under your Booklet and what services are not covered. In making these decisions, We do not promote or reward our employees or provider reviewers for withholding a benefit approval for Medically Necessary Covered Services that you are entitled to.

Medically Necessary Health Care Services

In administering benefits on behalf of the Plan, We determine whether services, procedures, supplies or visits are Medically Necessary. Only Medically Necessary services (except as otherwise provided in this Booklet), procedures, supplies or visits are Covered Services. Our medical policy uses current standards of practice and evaluates medical equipment, treatment and interventions with an evidence-based review of scientific literature. As medical technology is often changing, We also create or update policies to address new medications, devices and procedures. We review and update Our medical, behavioral health, and pharmaceutical policies on a regular basis. Those policies are considered part of this Booklet. In evaluating new technology and whether to consider it as eligible for coverage under Our policies, We consider peer-reviewed medical literature, consultations with Doctors, Specialists and other health care Providers, policies and procedures of government agencies and study results showing the impact of the new technology on long-term health.

Experimental/Investigational and/or Cosmetic Procedures

In administering benefits on behalf of the Plan, We will not pay for any services, procedures, surgeries or supplies that We consider Experimental/Investigational and/or cosmetic. Additionally We will not pay for complications arising from any services, procedures, surgeries or supplies that we consider Experimental/Investigational and/or cosmetic; except for services covered in conjunction with clinical trials as required by law.

Even if Medically Necessary and not Experimental or Investigational, and/or cosmetic, a service might not be covered. The benefits, exclusions and limitations of your coverage take priority over medical policy.

Certain procedures, diagnostic tests, Durable Medical Equipment, Home Care services, Home Intravenous services and medications require Preauthorization. It is the Provider's responsibility to preauthorize the test, equipment, service or procedure. See the **Appropriate Place and Preauthorization** section below for additional details.

Appropriate Place and Preauthorization

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

Preauthorization is a process We use to ensure that member care is provided in the most medically appropriate setting. The Preauthorization process may set limits on the coverage available under this Booklet. Preauthorization is required before a Hospital admission or before receiving certain procedures or services. Some drugs also require Preauthorization.

Preauthorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may determine that a service that was initially prescribed or requested is not Medically Necessary if you have not previously tried alternative treatments which are more cost effective.

The In-Network Provider who schedules an admission or orders the procedures or service is responsible for obtaining Preauthorization.

If you do not use an In-Network Provider you are only covered for Emergency and urgent services.

To determine which drugs and/or services require Preauthorization and/or to be sure that Preauthorization has been obtained, you may contact Us.

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

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

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

Unscheduled (Emergency) Admissions - We require notification of an Emergency admission within 48 hours after the admission. You are responsible for ensuring that We have been notified of the unscheduled admission unless you are unable to do so. Examples of Emergency admissions include admissions involving accidents or the onset of labor in pregnancy. Failure to notify Us may result in a reduction or denial of benefits.

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

Outpatient Procedures -- Many procedures performed on an outpatient basis must be preauthorized. Your Provider must call the phone number listed on the back of your Health Benefit ID Card for Preauthorization. You and Providers may visit Our website at www.anthem.com/CUHealthPlan or call Our Member Services department for a list of outpatient procedures and services that require Preauthorization. These services may be performed in a Hospital on an outpatient basis or in a freestanding facility, such as an Ambulatory Surgery center.

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

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

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

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

Ambulance Services - Some Ambulance services may need Preauthorization. All scheduled ground Ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be preauthorized. All air Ambulance services for non-emergency Hospital to Hospital transfers, except transfers from one acute Facility to another, must be preauthorized.

Prescription Drugs - Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. For a list of drugs that need Preauthorization or a Prescription Drug Prior Authorization Request form, please call the phone number on your Health Benefit ID Card or check our website at www.anthem.com/CUHealthPlan.

Urgent Prior Authorization - If the request is for urgently needed drugs, after We get the Prescription Drug Prior Authorization Request form:

- We will review the Urgent Prior Authorization Request and decide if We will approve or deny it within one business day of receiving the request. We will notify you, the prescribing Provider, and the dispensing pharmacy what We have decided.
- If more information is needed to make a decision, We will tell the prescribing Provider what information is needed within one business day of receiving the request.
- If the additional information requested from the prescribing Provider is not received within two business days of the prescribing Provider's receipt of the request, the request will be deemed denied. We will provide you, the prescribing Provider, and the dispensing pharmacy with confirmation of the denial within one business day of the date the request was deemed denied.
- Once the requested additional information is received, We will make a decision in accordance with applicable law.

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 provide you, the prescribing Provider, and the dispensing pharmacy with confirmation of the approval within one business day of the date the request was deemed approved.

Non-Urgent Prior Authorization - If the request is for non-urgently needed drugs, after We get the Prescription Drug Prior Authorization Request form through Our electronic pre-authorization system:

- We will review the request and decide if We will approve or deny it within two business days of receiving the request. We will notify you, the prescribing Provider, and the dispensing pharmacy.
- If more information is needed to make a decision, We will tell the prescribing Provider what information is needed within two business days of receiving the request.
- If the additional information requested from the prescribing Provider is not received within two business days of the prescribing Provider's receipt of the request, the request will be deemed denied. We will provide you, the prescribing Provider, and the dispensing pharmacy with confirmation of the denial within two business days of the date the request was deemed denied.
- Once the requested additional information is received, We will make a decision in accordance with applicable law.

Note: We must provide notification of approval or denial to you, the prescribing Provider, and the dispensing pharmacy within three business days upon receipt of a non-urgent prior authorization request received via facsimile, electronic mail, or verbally with associated written confirmation.

If We do not request additional information or provide notification of approval or denial within:

- Two business days of the receipt of an electronically filed non-urgent prior authorization request, as required by applicable law, the request will be deemed approved. We will provide you, the prescribing Provider, and the dispensing pharmacy with confirmation of the approval within two business days of the date the request was deemed approved; or
- Three business days of the receipt of a non-urgent prior authorization request that has been submitted via facsimile, electronic mail, or verbally with associated written confirmation, as required by applicable law, the request will be deemed approved. We will provide you, the prescribing Provider, and the dispensing pharmacy with confirmation of the approval within two business days of the date the request was deemed approved.

Appropriate Length of Stay

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

Concurrent Review

While you are in the Hospital, we will review your medical care to determine if you are receiving appropriate and Medically Necessary Hospital services. If you have an unscheduled admission to the Hospital for any reason, including a medical Emergency, maternity care, or alcohol detoxification, We **require** notification within 48 hours of the admission to assist with management of the Hospital benefits and planning for covered medical services during hospitalization and after discharge.

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

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

Retrospective Claim Review - Retrospective claim review consists of reviewing services after the services have been provided to determine if the services were provided as preauthorized, to evaluate claim charges and to review appropriateness of services billed based on available benefits, medical policy and Medical Necessity. We may request and review medical records to assist in payment decisions. If We determine that benefits are not available, neither the Trust nor We will pay.

Ongoing Care Needs

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

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

Care Management

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

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

Our Care Management program is tailored to the individual. In certain extraordinary circumstances involving intensive Care Management, We may, at Our sole discretion, provide benefits for alternate care that is not listed as a Covered Service in this Booklet. We may also extend Covered Services beyond the contractual benefit limits of this Booklet. We will make these decisions on a case-by-case basis. A decision in one case to provide extended benefits or approve care not listed as a Covered Service in one case does not obligate Us, or the Plan to provide or pay for the same benefits again to you or to any other Member. We and the Plan reserve the right, at any time, to alter or cease providing extended benefits or approving care not listed as a Covered Service. In such cases, We will notify you or your representative in writing.

Disease Management

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

Disease Management strategy includes working with you to promote self-management and encouraging compliance with the plan of care developed by your Provider. Disease Management emphasizes disease prevention, Member education and coordination of care to avoid acute episodes and/or gradual worsening of the disease over time.

The Disease Management programs may not be offered to all Plan Members who have specific, persistent or chronic conditions. A decision to offer a Disease Management program to you does not obligate Us, the Trust or Plan to offer other programs to you or to offer that program to other Members.

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

Our Participating Provider agreements may include financial incentives related to the provision of services and encourage participation in Disease Management programs. You may contact your Provider or Us for questions about such incentives.

Participation in Ongoing Needs Programs

There are several ways for you to become involved in one of Our Care Management or Disease Management programs. We can identify Members that We believe may benefit from the programs, or Physicians may refer their patients to Us.

THE BLUECARD PROGRAM

Like all Blue Cross & Blue Shield plans throughout the country, We participate in a program called "BlueCard." This program lets you get Covered Services at the In-Network cost-share when you are traveling out of state and need health care as long as you use a BlueCard Provider. All you have to do is show your Health Benefit ID Card to a participating Blue Cross & Blue Shield Provider, and they will send your claims to Us.

To find the nearest contracted Provider, you can visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the Member Services number on the back of your Health Benefit ID Card.

You can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Note: If you do not use an In-Network Provider you are only covered for Emergency and urgent services.

Care Outside the United States – BlueCard® Worldwide

Before you travel outside the United States, check with your Group or call Member Services at the number on your Health Benefit ID Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States is only for Emergency Care and Urgent Care or as approved by Us.

We suggest:

- Before you leave home, call the Member Services number on your Health Benefit ID Card for coverage details. Please note that you only have coverage for Emergency and Urgent Care services only when outside the United States.
- Always carry your up to date Health Benefit ID Card.
- In an Emergency, go straight to the nearest Hospital.
- The BlueCard Worldwide Service Center is on hand 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a health care professional, will arrange a Doctor visit or Hospital stay, if needed.

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the BlueCard Program Service Center, you must also call Us to get approval for benefits.

Payment Details

- **Participating BlueCard Worldwide Hospitals.** In most cases, when you make arrangements for a Hospital stay through BlueCard Worldwide, you should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs (non-Covered Services, Deductible, Coinsurance and/or Copayments) you normally pay. The Hospital should send in your claim for you.
- **Doctors and/or non-participating Hospitals.** You will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then you can fill out a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.
- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to Us.

Claim Forms

You can get international claim forms from Us, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for sending in claims is on the form.

MEMBERSHIP

Subscriber

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

An employee who has a regular work week, a Regent Board member, or a special category retiree as specified in the Plan Document is eligible to enroll for benefits as a Subscriber. The employee must contact the employer for the minimum number of hours that must be worked per week and other requirements to qualify for benefits.

Dependents

A Subscriber's Dependents (except a Regent Board member's dependents are not eligible for the Plan) may include the following:

- **Legal spouse.** As recognized under the laws of the state where the Subscriber lives.
- **Partner in a Civil Union.** All references to spouse in this Booklet include a partner in a civil union except a partner in a civil union is not eligible for COBRA coverage. There may be tax consequences to the Subscriber when enrolling his or her partner in a civil union and his or her partner's child. However a partner in a civil union and children of a partner in a civil union are eligible through the employer for continuation of coverage under the same time conditions and time periods as COBRA. Contact your employer for eligibility requirements.
- **Common-Law Spouse.** All references to spouse in this Booklet include a Common-Law Spouse. Contact your employer for eligibility requirements.
- **Same Gender Domestic Partner (SGDP).** All references to spouse in this Booklet include a SGDP except a SGDP is not eligible for COBRA coverage. There may be tax consequences to the Subscriber when enrolling his or her SGDP and his or her SGDP's child. However a SGDP and children of a SGDP are eligible through the employer for continuation of coverage under the same time conditions and time periods as COBRA. Contact your employer for eligibility requirements.
- **Newborn child.** A newborn child born to the Subscriber or Subscriber's Spouse is covered under the Subscriber's membership for the first 31 days after birth. If the mother of the newborn child is a Dependent child of the Subscriber, the newborn is **not** provided benefits (see the **Grandchild** heading in this section).

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

To continue the newborn child's participation in the coverage beyond the 31-day period after the newborn child's birth, the Subscriber must complete and submit a Benefits Enrollment/Change Form or online submission to your employer or submit the change through the online enrollment tool (as available through your employer) to add the newborn child as a Dependent child to the Subscriber's policy. Your employer must receive the Benefits Enrollment/Change Form or online submission within 31 days after the birth of the child to continue coverage for the 32nd day and thereafter. For example: the newborn child is born on January 15th, you have 31 days from the birth to notify the employer of the newborn's birth. If the current coverage is a single only policy and the child is to continue coverage beyond 31 days, the effective date of coverage for the newborn child is on the date of birth and the change in the premium payment is effective on February 1ST.

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

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

To continue the adopted child's participation in the Plan beyond the 31-day period after the adopted child's placement, the Subscriber must complete and submit a Benefits Enrollment/Change Form or online submission to your employer or submit the change through the online enrollment tool (as available through your employer) to add the adopted child as a Dependent child to the Subscriber's benefit Plan. The employer must receive the Benefits Enrollment/Change Form or online submission within 31 days after the placement of the child for adoption to continue coverage for the 32nd day and thereafter. For example: the placement of the adopted child is on January 15th, you have 31 days from the placement to notify the employer of the adoption. If the current coverage is a single only policy and the child is to continue coverage beyond 31 days, the effective date of coverage for the adopted child is on the date of placement and the change in the premium payment is effective on February 1ST.

- **Dependent child.** A Subscriber's son, daughter, stepson, stepdaughter or eligible foster child, including a legally adopted individual or an individual who is lawfully placed with the Subscriber for legal adoption, or a child for whom the Subscriber has established parental responsibility (as evidenced by court documents), or a son or daughter of a Subscriber's Civil Union Partner or SGDP, including a legally adopted individual or an individual who is lawfully placed with the Subscriber's Civil Union Partner or SGDP for legal adoption, or a child for whom the Subscriber's Civil Union Partner or SGDP has established parental responsibility (as evidenced by court documents), may be covered under the terms of this Booklet through the end of the calendar month in which the child turns 27. There may be tax consequences to the Subscriber when enrolling his or her child through the calendar month in which the child turns age 27. There may also be tax consequences to the Subscriber when enrolling his or her Civil Union Partner's or SGDP's child. A Dependent child of a Subscriber who is no longer eligible for coverage may be eligible for continuation coverage. Information can be found under the heading **Continuation of Benefits** in this section of this Booklet.
- **Disabled Dependent child.** An unmarried child who is 27 years of age or older, medically certified as disabled and dependent upon the parent may be covered under the terms of this Benefits Booklet. The employer must receive notice of the disability for the disabled Dependent coverage to continue after the Dependent child turns age 27.
- **Grandchild.** A grandchild of a Subscriber or a Subscriber's Spouse is not eligible for benefits unless the Subscriber or the Subscriber's Spouse is court-appointed as having parental responsibility for the grandchild or has adopted the grandchild. The Subscriber must submit a Benefits Enrollment/Change Form or online submission and evidence of court appointment as having parental responsibility or documents evidencing a legal adoption. Another option is to enroll the grandchild under a separate individual insurance policy with Anthem Blue Cross and Blue Shield, subject to its terms and conditions.

Medicare-Eligible Members

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

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

Enrollment Process

For eligible Subscribers and their eligible Dependents to participate in the Plan, the Subscriber must follow his/her employer's enrollment process, which details who is eligible and which applicable forms or online submission are required for enrollment. Eligibility for benefits under this Booklet begins as of the Effective Date as indicated in the employer's files. Services received before that date are not covered.

Note: Submission of a Benefits Enrollment/Change Form or online submission does not guarantee your enrollment.

You need to contact your employer for details regarding required documentation for adding a Common-Law Spouse, Partner in a Civil Union or SGDP and their dependents using the contacts below:

- University of Colorado – Employee Services
- UCHealth – Human Resources
- University Physicians, Inc. – Human Resources

Initial Enrollment

Eligible employees may apply for benefits for themselves and their eligible Dependents by submitting a Benefits Enrollment/Change Form or online submission. The employer must receive the Benefits Enrollment/Change Form or online submission within 31 days after the date of hire or within 31 days of the expiration of the waiting period, as defined in the employer's new hire policy. The Effective Date of eligibility for benefits will be determined in accordance with any established waiting period as determined by the employer. The employer will inform the employee of the length of the waiting period.

If you terminate your benefits under this Plan, and within the same Benefit Year you enroll in another CU Health Plan benefit plan administered by Us, due to a special enrollment, all covered benefits that have a Benefit Period Maximum will be carried over to the new coverage. For example, if a benefit has a limit of one visit per Benefit Period and you received that benefit under the prior plan, then you are not eligible under the new plan for the same benefit until the Benefit Period has expired, as benefits have been exhausted for your Benefit Period.

Open Enrollment

Any eligible employee may re-enroll each year during the employer's annual Open Enrollment period, which is generally 2-3 weeks before the Plan's Anniversary Date. The Employer will provide the Open Enrollment period dates to eligible employees. The plan year begins on July 1.

Newly Eligible Dependent Enrollment

A current Subscriber of this coverage may add a Dependent who becomes newly eligible due to a qualifying event. Qualifying events include marriage, partnership, birth, and placement for adoption or issuance of a qualified medical child support court order. The employer must receive a Benefits Enrollment/Change Form or online submission for the addition of the Dependent within 31 days after the date of the qualifying event. Eligibility for benefits will be effective on the first of the month following the qualifying event.

When the Subscriber or the Subscriber's Spouse is required by a qualified medical child support order to provide medical benefits, the eligible Dependent must be enrolled within 31 days of the issuance of such order. The employer must receive a copy of the court or administrative order with the Benefits Enrollment/Change Form or online submission.

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.

Special enrollment is available for eligible individuals who:

- Lost coverage due to death of a covered employee;
- Lost coverage due to a reduction in the number of hours of employment;
- Lost coverage under a health benefit plan due to the divorce or legal separation of the covered employee's spouse, SGDP or partner in civil union;
- Lost eligibility under their state's medical assistance program;
- Experienced a termination of employment or eligibility for coverage, regardless of eligibility for COBRA or state continuation;
- Experienced an involuntary termination of coverage;
- The covered employee became ineligible for benefits under Title XVIII of the Federal Social Security Act, as amended;
- Has a reduction or elimination of group contributions toward the cost of the prior health plan;
- Had a parent or legal guardian disenroll a dependent, or a dependent becomes ineligible for the Children's Basic health Plan;
- 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;
- Became eligible (employee or dependent) for premium assistance under their state's medical assistance regulations; or
- Entered into a Designated Beneficiary Agreement, or is required pursuant to a QMCSO or other court or administrative order mandating that the individual be covered.

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 state medical assistance program where the member resides, 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;

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.

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

waiver or demonstration project conducted under or in relation to these plans. Similarly, the employee must properly file an application with the employer within 60 days after the eligibility date for assistance is determined.

Military Service

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances listed below. These rights apply only to employees and their Dependents covered under the Plan before the employee leaves for military service. Benefits under USERRA continuation of coverage shall end on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

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.

How to Change Coverage

Because the Plan provides you with multiple health care options, eligible employees may change coverage for themselves and/or their eligible Dependents to another benefit Plan offered by the Plan during Open Enrollment.

Termination

Active Policy Termination

Your benefits end on the first occurrence of one of the following events:

- On the date the Plan described in this Booklet is terminated.
- Upon the Subscriber's death.
- When the required contribution has not been received by the employer.
- When you or your employer commits fraud or intentional misrepresentation of material fact.
- When you are no longer eligible for benefits under the terms of this Booklet.
- When the Subscriber's employer gives Us written notice that the Subscriber is no longer eligible for benefits. Benefits will be terminated as determined by the employer. We reserve the right to recoup any benefit payments made for dates of service after the termination date.
- When We receive written notification to cancel coverage for any Member, benefits will end at the end of the month following the written notification or at the end of the month of the qualifying event.
- When you move and therefore do not reside within the Service Area unless you are continuing coverage under COBRA/continuation coverage, you must notify your employer 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 and non-Urgent care will not be covered.
- If you do not notify your employer of a change of residence to an area outside Our Service Area, and We later become aware of the change, your benefits may be retroactively terminated to the date of the change of residence. You will be liable to Us and/or the Providers for payment for any services covered in error.
- 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. 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.
- When We cease operations.

Dependent Coverage Termination

To remove a Dependent from the Plan, the Subscriber must complete a Benefits Enrollment/Change Form or online submission. The change will be effective at the end of the month We are notified of the change. We reserve the right to recoup any benefit payments made after the termination date.

Benefits for a Dependent end on the last day of the month for the following qualifying events:

- When the Subscriber's employer notifies Us in writing to cancel benefits for a Dependent.
- When the Dependent child no longer qualifies as a Dependent by definition. Such a Dependent may be able to elect COBRA/continuation coverage.
- On the date of a final divorce decree or legal separation for a Dependent Spouse or Partner. Such a Dependent may be able to elect COBRA/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. 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.
- When legal custody of a child placed for adoption is terminated.
- Death of the Dependent.

What We Will Pay for After Termination

We, on behalf of the Plan, will not authorize payment for any services provided after your benefits end even if we preauthorized the service, unless prohibited by law. Benefits cease on the date your participation ends as described above. You may be responsible for benefit payments authorized by Us on your behalf for services provided after your benefits have been terminated.

We do **not** cover services received after your date of termination even if:

- We preauthorized the service; and/or
- The services were made necessary by an accident, illness or other event that occurred while benefits were in effect.

Continuation of Benefits

Family and Medical Leave Act

When an employee takes time off from work pursuant to the Family and Medical Leave Act, health insurance benefits remain in force but the employee may be required to continue paying the employee's share of the cost of such health benefits. You may contact your employer for details.

COBRA Continuation Rights Under Federal Law Continuation Coverage For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended and the parallel continuation coverage requirement under the Public Health Service Act ("COBRA"), you and/or your Dependents will be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that Plan's coverage area or the Plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- Your termination of employment for any reason, other than gross misconduct; or
- Your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- Your death;
- Your divorce or legal separation;
- Your entitlement to Medicare (Part A, Part B, or both); or
- For a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals, who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation. Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension for Your Dependents" are not applicable to these individuals.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation (unless they meet the federal definition of "qualified beneficiary"): domestic partners, same sex spouses, partners in a civil union, grandchildren (unless adopted by you), stepchildren (unless adopted by you), and children of a domestic partner/same sex spouse/partner in a civil union. However, they are eligible through your employer for continuation coverage under the same time conditions and time periods as COBRA.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; you become entitled to Medicare benefits (under Part A, Part B or both); or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) or the Public Employees' Retirement Association (PERA) Disability Program Administrator to be totally disabled under Title II or XVI of the Social Security Act, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event. To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA/PERA must determine that the disability occurred during the first 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA/PERA determination must be provided to the COBRA Plan Administrator within 60 calendar days after the date the SSA/PERA determination is made AND before the end of the initial 18-month continuation period. If the SSA/PERA later determines that the individual is no longer disabled, you must notify the COBRA Plan Administrator within 30 days after the date the final determination is made by SSA/PERA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA/PERA makes a final determination that the disabled individual is no longer disabled. All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA/Continuation Coverage

COBRA/continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA/continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- when the Plan ceases to provide any group health plan, including successor plans to any employee;
- after electing COBRA/continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both); after electing COBRA/continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage. In such case coverage will continue until the earliest of: the end of the applicable maximum period; or the occurrence of an event described in one of the first three bullets above; or
- any reason the Plan would terminate coverage of a Member or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Your CU Health Plan's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of this Plan's Service Area or this Plan eliminates a Service Area in your location, you may elect to continue COBRA/continuation coverage under another CU Health Plan you are eligible for, otherwise your COBRA/continuation coverage under the Plan will be limited to emergency and urgent services only. Because the Plan does not provide out-of-network coverage, nonemergency and non-urgent services will not be covered under the Plan outside of its Service Area.

Plan Notification Requirements

The Plan, through your Employer (for the initial notification), and the COBRA Plan Administrator (for the COBRA/continuation coverage election notice) are required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA/continuation rights must be provided within 90 days after your (or your spouse/partner's) coverage under the Plan begins (or the Plan first becomes subject to COBRA/continuation requirements, if later).
 - If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA/continuation coverage election notice as explained below.
- A COBRA/continuation coverage election notice must be provided to you and/or your Dependents
 - Within 44 days after loss of coverage under the Plan for your termination of employment or reduction of hours, your death, your becoming entitled to Medicare and/or employer bankruptcy, and
 - No later than 14 days after the end of the period in which you and/or your qualified beneficiary(ies) notify the COBRA Plan Administrator of certain other qualifying events as described below.

How to Elect COBRA/Continuation Coverage

The COBRA/continuation coverage election notice will list the individuals who are eligible for COBRA/continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA/continuation coverage. You must notify the COBRA Plan Administrator of your election no later than the due date stated on the COBRA/continuation coverage election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA/continuation coverage election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA/continuation coverage. If you reject COBRA/continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date. Each qualified beneficiary has an independent right to elect COBRA/continuation coverage. COBRA/continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse or partner may elect COBRA/continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA/continuation coverage in order for your Dependents to elect COBRA/continuation coverage.

How Much Does COBRA/Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of COBRA/continuation coverage. The amount may not exceed 102% of the cost of the group health plan (including both employer and Member contributions) for coverage of a similarly situated active Member or family Member. The premium during the 11-month disability extension may not exceed 150% of the cost of the group health plan (including both employer and Member contributions) for coverage of a similarly situated active Member or family Member. For example: If the Member alone elects COBRA/continuation coverage, the Member will be charged 102% (or 150%) of the active Member premium. If the spouse or one Dependent child alone elects COBRA/continuation coverage, he or she will be charged 102% (or 150%) of the active Member premium. If more than one qualified beneficiary elects COBRA/continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA/Continuation Premiums

First payment for COBRA/continuation coverage

If you elect COBRA/continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within those 45 days, you will lose all COBRA rights and continuation allowance under the Plan.

Subsequent payments

After you make your first payment for COBRA/continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA/continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that

payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA/continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the your employer within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.

The occurrence of a secondary qualifying event is discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period). (Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Member covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, partnership, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA/continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA/continuation coverage for the remainder of the coverage period following your early termination of COBRA/continuation coverage or due to a secondary qualifying event. COBRA/continuation coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA/Continuation for Retirees Following Employer’s or Trust’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to your employer or the Trust under Title 11 of the United States Code, you may be entitled to COBRA/continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Health Coverage Tax Credit (“HCTC”)

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Members who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). The Trade Adjustment Assistance Extension Act of 2011 increased the amount of the HCTC, expanded those eligible to receive it, and extended the COBRA coverage. Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the HCTC is also available at www.irs.gov by entering the keyword “HCTC.” In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under “Termination of COBRA Continuation” above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify your employer immediately.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

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.

COVERED SERVICES

This section describes Covered Services available under your health care benefits when provided and billed by eligible Providers. Covered Services and supplies are only benefits if they are Medically Necessary or preventive, not otherwise excluded under this Benefits Booklet as determined by Us and obtained in the manner required by this Benefits Booklet. All services must be standard medical practice where they are received for the illness, injury or condition being treated, and they must be legal in the United States. Covered Services shall meet or exceed requirements of all applicable insurance law.

The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and does not guarantee payment by Us. You must contact Us for certain services to be sure that Preauthorization has been obtained by the ordering Provider.

A PCP provides you with basic health services and other medical services. Sometimes the PCP determines that it is necessary, or you request, to see a Specialist or other Provider. Your PCP must recommend and coordinate any care provided by other health care providers. This is accomplished through a Referral. A Referral is the formal recommendation, made by the PCP or other physician, so that you may receive care from a Specialist or a different Provider. Services received without a Referral are not covered and you will be liable for all costs incurred when not obtained without a Referral. Referral guidelines can be found under the heading REFERRALS in the ABOUT YOUR HEALTH COVERAGE section. A Referral is not complete until We have approved the Referral. The requesting Provider will receive notification of approval of a Referral. You may also contact the PCP or the medical management group listed on the back of your Health Benefit ID Card to receive verification that a Referral has been approved. If you use an Out-of-Network Provider, your claim will be denied unless services were for Emergency or Urgent care, or preauthorized by Us.

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

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

Preventive Care Services

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

Preventive Care services include Outpatient services and Physician Office services, screenings and other services for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition, but instead benefits will be considered under the Physician Office Services or Diagnostic Services benefits.

Preventive Care Services in this section shall meet requirements as determined by federal and state law, including but not limited to the Patient Protection and Affordable Care Act (PPACA), and become effective in accordance with those laws. Many preventive care services are covered by this Booklet with no Deductible, Coinsurance and/or Copayments when provided by a Participating/In-Network Provider. That means that We pay 100% of the Maximum Allowed Amount. These services fall under the following broad categories as shown below:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
 - Breast cancer;
 - Cervical cancer;
 - Colorectal cancer;
 - High Blood Pressure;
 - Type 2 Diabetes Mellitus;
 - Cholesterol; and
 - Child and Adult Obesity.

2. 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.
3. Preventive care and screenings for children, adolescents, and adults as provided for in the comprehensive guidelines supported by 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 the Health Resources and Services Administration, including the following:

- Women’s contraceptives, sterilization procedures, and counseling. This includes Generic Drugs for birth control as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants are also covered. You must get covered contraceptives from an In-Network pharmacy or participating Provider, if you don’t they will not be covered. Multi-Source Drugs will be covered under the Retail Pharmacy/Mail Order Prescription Drugs section below.
- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
- Gestational diabetes screening.

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.

You may call Member Services using the number on your Health Benefit ID Card for additional information about these services. You may also view the following federal websites:

www.HealthCare.gov; and

www.CDC.gov.

Preventive medical nutrition counseling services are not subject to and do not lower the nutritional therapy limit as listed on the *Summary of Benefits and Coverage*.

Covered Services also include the following services:

- Routine screening mammogram;
- Routine cytologic screening (pap test);
- Cervical cancer vaccinations for females;
- 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;
- Annual medical diabetes eye exams, or in accordance with the frequency determined by your Provider; and
- Flu shot when received from your Provider’s office. If it’s more convenient to get your flu shot at a flu shot clinic, you may be eligible for reimbursement of some or all of your out of pocket costs. Reimbursement for one flu shot per Benefit Period, or as determined by Us, may be available at locations such as a flu shot clinic location. Examples of locations that may provide flu shots and may be considered flu shot clinics include your local pharmacy, your place of employment, a grocery store, Wal-Mart, Walgreens or Costco. There may be additional flu shot clinic locations available to you. The claim form you need to submit for reimbursement and the reimbursement amount is available on Our website at www.anthem.com/CUHealthPlan or you can call Our Member Services department. This annual reimbursement is subject to change. Your cost for a flu shot otherwise paid for in full or in part by another party, is not eligible for reimbursement.

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

Infertility Services

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

Benefits include Inpatient Services, Outpatient Services, and Physician Office Services for the diagnosis of infertility. Covered Services include diagnostic and exploratory procedures of an underlying medical condition up to the point an infertility condition is diagnosed. In addition, once the infertility diagnosis has been determined, treatment is limited to those conditions requiring surgical treatment for correction (e.g., opening an obstructed fallopian tube, epididymis, or vas deferens).

Maternity Services and Newborn Care

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

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

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

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

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

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

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

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

We pay for Covered Services from a Provider for therapeutic termination of pregnancy. Covered Services are provided only to the extent necessary to prevent the death of the mother or unborn child.

Diabetes Management Services

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

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

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

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

Screenings for gestational diabetes are covered under the Preventive Care Services section of this Booklet.

More details on how diabetic supplies, equipment, injectable insulin and diabetic medication are covered can be found in the **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES** section and the **RETAIL PHARMACY/MAIL ORDER PRESCRIPTION DRUGS** section of this Booklet.

Physician Office Services

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

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

Covered Physician office services include visits for medical care, including birth control, consultations and second opinions to: examine, diagnose and treat an illness or injury performed in the Physician's office. Office visits also include allergy injections and allergy serum, allergy testing and non-urgent or non-emergency care. Office visits may include administration of injections. If the office visit is with a physician other than the PCP, a Referral must have been approved prior to the visit. See the section under **PRESCRIPTION DRUGS ADMINISTERED BY A MEDICAL PROVIDER** for more information on prescription drugs administered in the office.

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

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

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

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

When available in your area, your coverage may include online visit services. Covered Services include a medical session 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.

Inpatient Services

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

Inpatient Services do not include care related to Maternity Services, Mental Health and/or Substance Abuse Services, except as specified.

Inpatient Services include:

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

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 include:

- A room with two or more beds;
- A private room, however the allowance is the Provider's average semi-private room rate unless it is Medically Necessary that you occupy a private room. For 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; and
- A room in a Special Care Unit approved by Us. The Special Care Unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary Services include:

- Operating, delivery and treatment rooms and equipment;
- Prescribed drugs administered as part of the Inpatient admission;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services;
- Therapy Services;
- General nursing care; and
- Charges for processing, transportation, handling and administration 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.

Professional Services include:

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

Inpatient Rehab Services

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

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 and Coverage*.

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 and Coverage*; or
- We decide that Maximum Medical Improvement is reached and no further major changes can be made.

Skilled Nursing Care Facility (SNF)

A Skilled Nursing Care Facility is a place that gives you skilled nursing care. Benefits are for charges from a Skilled Nursing Care 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 Care Facility coverage does not include care for Members with significant medical needs. Also, benefits are not available for Custodial Care. The Facility Provider and its service must be covered and Preauthorized by Us.

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 and Coverage*. 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 Care Facility services will be denied.

Outpatient Services

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

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.

See the "Prescription Drugs Administered by a Medical Provider" subsection of the "Covered Services" section of this Booklet for more information on Prescription Drugs administered as an outpatient procedure.

Diagnostic Services

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

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

- X-ray and other radiology services;
- Laboratory and pathology services;
- Cardiographic, encephalographic and radioisotope tests;
- Ultrasound services;
- Allergy tests;
- Hearing tests, unless related to an examination for prescribing or fitting of a hearing aid, except as required by applicable law;
- Genetic testing when allowed by the Trust and Our medical policy; and
- Ultrafast CT scans when Preauthorized and allowed by the Trust and Our medical policy.

Surgical Services

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

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

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Sterilization services;
- Anesthesia and surgical assistance as determined by our medical policy. We do not pay for all surgical assistant procedures;
- Usual and related pre-operative and post-operative care;
- Other procedures as approved by Us; and
- Bariatric surgery for treatment of clinically severe obesity, as defined by the body mass index (BMI). Benefits for Bariatric surgery include coverage for needed pre-operative weight loss programs and services.

The surgical fee includes normal post-operative care.

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

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages 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 Deductible, Coinsurance and/or Copayment provisions otherwise applicable under the plan.

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

Emergency Care and Urgent Care

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

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

Emergency Care

An Emergency is where a prudent person, having average knowledge of health services and medicine and acting reasonably, believes that immediate medical care is needed to prevent death or serious harm to life or limb. 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 services needed to screen and Stabilize you without Preauthorization. But once you are stabilized any further or follow-up care is not considered Emergency care.

For inpatient admissions after Emergency care, you should get in touch with Us within forty-eight hours of being in 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 is not an Emergency. 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.

Urgent Care can be received from an In-Network Provider or an Out-of-Network Provider. If you visit an Out-of-Network Provider your Cost Shares may be higher.

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.

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

Obtaining Emergency or Urgent Care

If you need Emergency Care or Urgent Care, even while you are away from home, 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 Emergency Room. 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 Emergency Room;
- Call your Doctor or Us within forty-eight hours or as soon as you reasonably can;
- Ask if the Emergency Room or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan. More than likely it does;
- If the Emergency Room or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, show your Health Benefit ID Card to the Emergency Room staff or Doctor. If the Emergency Room 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 Emergency Room or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, the Emergency Room 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 *Schedule of Benefits*; and
- You will receive an Explanation of Benefits form.

Ambulance and Transportation Services

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

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

Ambulance services are subject to Medical Necessity reviews by Us. When using an air Ambulance for non-Emergency transportation, We reserve the right to select the air Ambulance Provider. For non-Emergency services if you do not use the air Ambulance Provider We select, the Out-of-Network Provider may bill you for any charges that exceed the Our Maximum Allowed Amount. 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.

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 or water 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

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

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

Physical, Occupational and Speech Therapy

From the Member's birth until the Member's sixth (6th) birthday, benefits are allowed up to the maximum visits listed on the *Summary of Benefits and Coverage*, or forty (40) visits each, whichever is greater, per Benefit Period for physical, speech and occupational therapies. Benefits are for the care and treatment of congenital defects and birth abnormalities for covered children without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. The level of benefits between the third (3rd) birthday and the sixth (6th) birthday shall exceed the limit of forty (40) visits for each therapy if such therapy is indicated in a Member's Treatment Plan for Autism Spectrum Disorders and is determined by Us to be Medically Necessary.

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

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

- **Physical Therapy** including treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function and to prevent disability following illness, injury or loss of a body part, or as a result of a Congenital Defect or Birth Abnormality.
- **Speech Therapy** for the correction of a speech impairment resulting from illness, injury, surgery or as a result of a Congenital Defect or Birth Abnormality as determined by your CU Health Plan and Anthem Blue Cross and Blue Shield/HMO Colorado's medical policy.
 - **Cleft Palate or Cleft Lip.** For a cleft palate or cleft lip condition, Speech Therapy benefits are unlimited, as long as Medical Necessity has been demonstrated. Such Speech Therapy visits reduce the maximum visits but are not limited to the maximum visits. Additional services for cleft palate or cleft lip can be found under the **DENTAL RELATED SERVICES** section of this Booklet.
- **Occupational Therapy** for the treatment of a person with physical disabilities or as a result of a Congenital Defect or Birth Abnormality. By means of constructive activities, occupational therapy is designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living. It also includes tasks required by the person's particular occupational role.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. Benefits are allowed at a facility for exercise and education under the direct supervision of skilled program personnel in an intensive outpatient rehabilitation program. Up to 36 visits per cardiac event are allowed based on Our Medical Policy.
- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents. Chemotherapy services are available through the Provider's office and are subject to the Specialist copayment. See the section under **PRESCRIPTION DRUGS ADMINISTERED BY A MEDICAL PROVIDER** for more information on prescription drugs administered as part of a chemotherapy visit.
- **Dialysis** treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.
- **Radiation Therapy** for the treatment of disease by x-ray, radium or radioactive isotopes.
- **Inhalation Therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

Autism Services

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

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

- a) Evaluation and assessment services;
- b) Behavior training and behavior management and applied behavior analysis, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, for autism spectrum disorders provided by autism services providers;
- c) Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies;
- d) Prescription Drugs, if covered under this Booklet;
- e) Psychiatric Care;
- f) Psychological Care, including family counseling; and
- g) Therapeutic Care.

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

Chiropractic and Acupuncture Therapy

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

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 and Coverage*.

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; and
- the services are usually given to diagnose or treat a neuromusculoskeletal health problem linked to an injury or illness.

Acupuncture is the use of needles inserted along specific nerve pathways. Benefits are limited up to the number of visits as listed on the *Summary of Benefits and Coverage*.

Physical Medicine and Rehabilitation Services

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

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

The variety and intensity of treatments required is the major differentiation from an admission primarily for Physical Therapy.

Home Care/Home IV Therapy Services

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

Services performed by a Home Health Agency or other Provider in your residence. The Services must be provided on a part-time visiting basis according to a course of treatment. Covered Services include the following:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.);
- Medical/social services;
- Diagnostic Services;
- Nutritional guidance;
- Certified Nurse Aide services under the supervision of an R.N. or a therapist qualified with professional nursing services;
- Therapy Services (not subject to the therapy limits listed under the **THERAPY SERVICES** section or on the *Summary of Benefits and Coverage* when provided by a Home Care Agency);
- Medical and Surgical Supplies;
- Durable Medical Equipment; and
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).

Home IV Therapy

Home IV therapy is covered and includes a combination of nursing, Durable Medical Equipment and IV pharmaceutical services that are delivered and/or administered intravenously in the home. Home IV Therapy includes services and supplies such as for Total Parenteral Nutrition (TPN), Antibiotic therapy, pain management and Chemotherapy. TPN received in the home is a covered benefit for the first 21 days following a Hospital discharge when it is determined to be Medically Necessary. Additional days may be allowed up to a maximum of 42 days per Benefit Period when preauthorized by Us. See the section under **PRESCRIPTION DRUGS ADMINISTERED BY A MEDICAL PROVIDER** for more information on prescription drugs administered for more information.

Nutritional Counseling

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

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.

Benefits include:

- Nutritional techniques of evaluation which give measurements and changes;
- Nutritional counseling;
- Nutritional therapy; and
- 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 in this section are subject to the **GENERAL EXCLUSIONS** section of this Booklet.

Benefits are provided for medical foods for home use for metabolic disorders, which may be taken orally or enterally. A Provider must have prescribed the medical foods that are designed and manufactured for inherited enzymatic disorders involved in the metabolism of amino, organic, and fatty acids. Such disorders include phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders,

hyperlysinemia, glutaric acidemias, methylmalonic acidemia and propionic acidemia. The maximum age to receive benefits for phenylketonuria is 21 years of age, except the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is 35 years of age. This benefit does not include enteral nutrition therapy or medical foods for Members with cystic fibrosis or lactose- or soy- intolerance.

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

Hospice Care Services

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

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; and
- 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

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

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 Preauthorized. This includes necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloblastic therapy.

Covered transplant procedures include:

- Heart;
- Lung (single or double);
- Heart-Lung;

- Kidney-Pancreas;
- Pancreas;
- Liver;
- Kidney;
- Cornea;
- Bone Marrow/Peripheral Stem Cell/Cord Blood;
- Small bowel; and
- Multivisceral.

This list may change based on Our medical policy. 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 are covered if they are prescribed for outpatient use with a covered human organ and tissue transplant, given only by written prescription, and approved for general use by the Food and Drug Administration.

As used under this section, the term donor means a person who gives organs for transplantation. If a human organ or tissue transplant is given from a donor to the person receiving the transplant, the following apply:

- When both the person getting the transplant and the person donating the organ are Our covered Members, each is entitled to the Covered Services given under the human organ and tissue transplant benefits;
- When only the person getting the transplant is a covered Member, the person donating and the person getting the transplant are entitled to the Covered Services given under the Human Organ and Tissue Transplant benefits;
- The donor benefits are limited to those not given or available to the donor from any other source. This includes, but is not limited to, other insurance coverage, grants, foundations, government programs, etc.; and
- If the person giving the organ is Our covered Member, and the person getting the transplant is not covered by Us, benefits will not be given for the donor or recipient expenses.

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 are given for donor searches that are not part of your family for bone marrow/stem cell transplants for a covered transplant procedure.

In-Network Transplant Provider

We must designate and approve the Hospital performing the specific Covered Services provided under this benefit. A Provider that We have chosen as a “Center of Excellence,” a Provider selected to take part as an In-Network transplant Provider and/or a University Hospital provider may be designated and approved to be an In-Network Transplant Provider. The Provider has entered into a transplant Provider agreement to give covered transplant procedures and certain administrative duties for the transplant network.

Please note, not every designated Hospital performs each of the specified Covered Services. Even if a Hospital is an In-Network Provider for other Covered Services, it may not be an approved Hospital for Human Organ and Tissue Transplants.

A Provider may be an In-Network transplant Provider for:

- Certain covered transplant procedures; or
- 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 Preauthorization

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 Preauthorization prior to the transplant whether this is performed in an inpatient or outpatient setting.

Preauthorization 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 Preauthorization to Us as soon as possible to start this process. Not getting Preauthorization will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for HLA testing, donor searches and/or a harvest 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 harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or harvest 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 60 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 and Coverage*.

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 and Coverage*.

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; and
- Any Covered Services for a covered transplant procedure received before or after the Transplant Benefit Period. Note: the harvest 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

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

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

Medical and Surgical Supplies

Covered Services include:

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

Durable Medical Equipment/Oxygen

Covered Services include:

- The rental (or, at Our option, the purchase) of Durable Medical Equipment prescribed by a Physician or other Provider. Rental costs must not be more than the purchase price. This equipment must serve only a medical purpose and be able to withstand repeated use. Repair of medical equipment is covered;
- Oxygen and the rental of the equipment needed to administer oxygen (one stationary and one portable unit per member) are covered;
- Colostomy and ostomy supplies are also covered;
- Breast prostheses and two surgical brassieres each Benefit Period while the member is covered by the plan following a mastectomy; and
- The first wig following cancer treatment.

Prosthetic Devices

Covered Services include:

- Purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
 - Replace all or part of a missing body part and its adjoining tissues; or
 - Replace all or part of the function of a permanently ineffective or malfunctioning body part.

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

Covered Services for prosthetic devices include:

- Either one set of standard prescription eyeglasses or one set of contact lenses (whichever is appropriate for the medical condition) when necessary to replace human lenses absent at birth or lost through intraocular Surgery, ocular injury or for the treatment of keratoconus or aphakia.

Orthopedic Appliances

Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of:

- orthopedic braces;
- supplies that are rigid or semi-rigid;
- supportive devices which limit or stop motion of a weak or diseased body part; and
- podiatric shoe inserts.

Non-covered items include but are not limited to:

- Orthotics and orthopedic shoes (except if you are diagnosed with diabetes); and
- Items which are not prescribed by contracting providers.

Diabetic Supplies and Equipment

Covered Services include:

- Diabetic supplies such as needles, syringes, lancets, test strips and tablets; and
- Diabetic equipment such as insulin pump, glucose monitor.

Hearing Aid Services

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

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

- Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be provided as part of the **DIAGNOSTIC SERVICES** section of this Booklet;
- Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment. Initial and replacement hearing aids will be supplied every 60 months, or when alterations to the existing hearing aid cannot adequately meet the child's needs; and
- Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

The following hearing aid services are covered for Members 18 years of age and older.

- Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. Audiological evaluations are subject to the Specialist copayment;
- Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment; and
- Visits for fitting, counseling, adjustments and repairs after receiving the covered hearing aid.

Dental Related Services

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

Accident-Related Dental Services

Emergency Care Services and Urgent Care Services for dental work and oral Surgery are covered. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

Benefits are provided for accident-related dental expenses when the Member meets all of the following criteria:

- Dental services, supplies and appliances are needed because of an accident in which the Member sustained other significant bodily injuries outside the mouth or oral cavity.
- Treatment must be for injuries to your sound natural teeth.
- An injury that results from chewing or biting is not considered an accident, unless the chewing or biting results from a medical or mental condition.
- Treatment must be necessary to restore your teeth to the condition they were in immediately before the accident.
- The first dental services must be performed within 90 days after your accident.
- Related services must be performed within one year after your accident. Services after one year are not covered even if coverage is still in effect.

Benefits for restorations are limited to those services, supplies, and appliances We determine to be appropriate in restoring the mouth, teeth, or jaws to the condition they were in immediately before the accident.

Outpatient Services, Physician Office Services, Emergency Care Services and Urgent Care Services for dental work and oral Surgery are charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

Dental Anesthesia

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

Cleft Palate and Cleft Lip Conditions

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

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

Mental Health and Substance Abuse Services

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

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. 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. This care is covered when given by a covered Provider.

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.

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.

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.

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.

Preauthorizations. 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 Preauthorization. See the “Managed Care Features” section of this Booklet for information.

Prescription Drugs Administered by a Medical Provider

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

We cover Prescription Drugs when they are administered to you as part of a Doctor’s visit, home care visit, or at an outpatient facility. This includes drugs for infusion therapy, chemotherapy, specialty drugs, blood products, and office-based injectable drug that must be administered by a Provider. This section applies when your Provider orders the drug and administers it to you.

Benefits for drugs that you can inject or get at a Pharmacy (i.e., self-administered injectable drugs) are not covered under this section. Benefits for those drugs are described in the Retail Pharmacy/Mail Order Prescription Drugs or Specialty Pharmacy Drugs sections.

Note: When Prescription Drugs are covered under this benefit, they will not also be provided under the Retail Pharmacy/Mail Order Prescription Drugs or Specialty Pharmacy Drugs benefits. Also, if Prescription Drugs are covered under the Retail Pharmacy, Mail Order Prescription Drugs or Specialty Pharmacy Drugs benefits, they will not be covered under this benefit.

Important Details About Prescription Drug Coverage

Your plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked for more details before We can decide if the drug is

Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics (P&T) Process.

Preauthorization

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

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

For a list of drugs that need Preauthorization, please call the Pharmacy phone number on your Health Benefit ID Card. The list will be reviewed and updated from time to time. Including a drug or related item on the list does not promise coverage under this Booklet. Your Provider may check with Us to verify drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic drugs are covered under this Booklet.

Step Therapy

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

Therapeutic Substitution

Therapeutic substitution is an optional program that tells you and your Doctor about alternatives to certain prescribed drugs. We may contact you and your prescribing Doctor to make you aware of these choices. Only you and your Doctor can determine if the therapeutic substitute is right for you. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, please call the Pharmacy phone number on your Health Benefit ID Card.

Retail Pharmacy/Mail Order Prescription Drugs

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

This section describes the outpatient pharmacy benefits for medications obtained through a Retail Pharmacy or Mail-Order Pharmacy. You must obtain covered Prescription Drugs and supplies from an In-Network pharmacy. All Prescription Drugs must be a Legend Drug and on the preferred formulary drug list to be eligible for benefits.

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 costs. You may request, or your Provider may order, the Brand Name Drug. However, if a Generic Drug is available, you will need to pay the cost difference between the Generic and Brand Name Drug in addition to your pharmacy tier copayment. The cost difference between the Generic and Brand Name Drug does not contribute to 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.

The Covered Services under this section do not include those received in the Hospital as an Inpatient. Refer to the **INPATIENT SERVICES** section for services covered by the Booklet. For medications or equipment not obtained through a pharmacy, see the **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES** section of this Booklet. For Prescription Drugs, including Specialty Pharmacy Drugs, which are administered to you in a medical setting (e.g., Physician’s office, home care visit, or outpatient Facility), see **PRESCRIPTION DRUGS ADMINISTERED BY A MEDICAL PROVIDER** section for more information.

You may fill your prescriptions through the UHealth Retail Pharmacies, or through one of Anthem’s Participating Retail Pharmacies. Mail Order prescriptions are managed by the University of Colorado Hospital Mail Order Prescription Service.

We have established a Pharmacy and Therapeutics (P&T) Process, in which health care professionals, including nurses, pharmacists and doctors determine the clinical appropriateness of drugs and promote access to quality medications. This process also reviews drugs to determine the most cost effective use of benefits and advise on programs to help improve care. Our programs may include, but are not limited to, drug utilization programs, Preauthorization criteria, therapeutic conversion programs, cross-branded initiatives and drug profiling initiatives.

In addition We use the cost of the drug relative to other drugs in its therapeutic class or used to treat the same or similar condition, the availability of over-the-counter choices and where appropriate, certain clinical economic factors.

You may review the current preferred formulary drug list on Our website at www.anthem.com/CUHealthPlan. You may also request a copy of the preferred formulary drug list by calling Our Member Services department. The preferred formulary drug list is subject to periodic review and amendment. Inclusion of a drug or related item on the preferred formulary drug list is not a guarantee of coverage.

When you have your prescription filled at one of Our Retail Pharmacies, benefits available under this Booklet are managed by the Pharmacy Benefits Manager (PBM). The PBM is the entity with which We have contracted to administer its prescription drug benefits. The PBM offers a nationwide network of Retail Pharmacies and clinical services.

For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before We will determine Medical Necessity. We may, at Our sole discretion, establish quantity limits for specific Prescription Drugs.

Your Deductible, Coinsurance and/or Copayment amount depends upon which tier the Prescription Drug falls under as follows:

Tier-1 – Generic Drugs;

Tier-2 – Brand Name Prescription Drugs;

Tier-3 – Non-preferred Brand Name Prescription Drugs; and

Tier-4 – Specialty Oral and Injectable Prescription Drugs.

See the *Summary of Benefits and Coverage* to determine the associated Deductible, Coinsurance and/or Copayment for each tier.

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

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

The Provider or pharmacist can check with Us to verify drug placement, any quantity limits, Step-Therapy, Preauthorization requirements, or appropriate Brand or Generic drugs recognized under the Booklet.

Outpatient pharmacy benefits may include a therapeutic drug substitution program approved by Us and managed by Our pharmacy affiliate. This is a voluntary program designed to inform you and Physicians about generic alternatives. The pharmacy affiliate may contact you and the prescribing Physician to make you aware of the generic drug substitution options. Therapeutic substitutions may also be initiated at the time the prescription is dispensed. Only you and the Physician together can determine whether the therapeutic substitute is appropriate for you.

Outpatient pharmacy benefits received from a retail pharmacy or Mail-Order Pharmacy are limited to:

- Prescription Drugs, including self-administered injectable drugs. These are Prescription Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit in this section;
- Injectable insulin. Members diagnosed with diabetes may be eligible to have diabetic medication filled with no Copayment. Please contact Member Services or visit www.anthem.com/CUHealthPlan for additional information;
- Oral contraceptive drugs and contraceptive devices. Certain contraceptives are covered under Preventive Care Services;
- Certain supplies, equipment and appliances (such as those for diabetes and asthma). You may contact Us to determine supplies covered through a pharmacy;
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the Preventive Care Services section; and
- FDA approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 and older. These products will be covered under the "Preventive Care Services" section.

Each prescription is subject to Deductible, Coinsurance and/or Copayment. If the prescription order includes more than one covered drug or supply, a separate Deductible, Coinsurance and/or Copayment is required for each covered drug or supply. The Deductible, Coinsurance and/or Copayment is based on the Prescription Drug Maximum Allowed Amount. The Deductible, Coinsurance and/or Copayment will not be reduced by any discounts, rebates or other funds received by

UCHealth, Us or the PBM from drug manufacturers, or similar vendors and/or funds received by UCHealth, Us and or the PBM. We will make no payment for any covered drug or supply unless the Prescription Drug Maximum Allowed Amount exceeds any applicable Deductible, Coinsurance and/or Copayment for which you are responsible.

See the Summary of Benefits and Coverage to determine the associated Deductible, Coinsurance and/or Copayment.

You are limited to up to a 30-day supply of a prescription drug if obtained at a Retail Pharmacy or up to a 90-day supply if received through the UCH Mail Order Prescription Service Pharmacy. For oral contraceptives, you are limited to one pill pack (normally 28 days) at a Retail Pharmacy, or three pill packs by the UCH Mail Order Prescription Service Pharmacy. When Medically Necessary, a one-month vacation override is available with applicable Deductible, Coinsurance and/or Copayment and quantity restrictions if you are traveling out of Our Service Area.

For a list of In-Network Pharmacies see our website at www.anthem.com/CUHealthPlan.

Specialty Pharmacy Drugs

Specialty Pharmacy Drugs are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at a Retail Pharmacy or through a Mail Order Pharmacy. Specialty Pharmacy Drugs are available on an In-Network basis from any Specialty Pharmacy including UCHealth. If Specialty Pharmacy Drugs are purchased from a Retail Pharmacy they will be considered as Out-of-Network and not covered.

The Outpatient Specialty Pharmacy benefits available under this Booklet may be managed by the Pharmacy Benefits Manager (PBM). The PBM is the company that We have contracted with to administer the Prescription Drug benefits including Specialty Pharmacy Drugs. The PBM offers a Specialty Pharmacy which sends medications to you by overnight mail or mail service for up to a 30-day supply (you cannot pick up your medication from the Specialty Pharmacy). A Specialty Pharmacy is not a Retail Pharmacy or a Home Delivery Pharmacy.

We use many different administrative processes and tools, such as Preauthorization for health care services. These help Us decide the most right use and cost-effective alternatives available to Our Members. Certain Specialty Pharmacy Drugs may require Preauthorization. At the time you fill a prescription, you will be informed if Preauthorization is needed. For a list of current drugs requiring Preauthorization, contact Our Member Services, or review the list on Our website at www.anthem.com/CUHealthPlan. You can also contact Us to check on the drug tier placement or Preauthorization requirements.

It is your responsibility to assure that if Preauthorization is required, it has been obtained prior to filling a Specialty Drug Prescription for the drug to be a covered benefit. Specialty drugs are limited to a 30 day supply when filled at Our Specialty UCHealth or Retail Pharmacy PBM. After 3 fills from a Retail Pharmacy the prescription must be filled by a UCHealth Pharmacy. A list of the Specialty Pharmacy Drugs that are covered is available from Our Member Services department or may be found on Our website at www.anthem.com/CUHealthPlan.

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

You or your Doctor may order your Specialty Pharmacy Drug from the Specialty Pharmacy. A dedicated care coordinator will guide you or your Doctor through the process up to and including actual delivery of your Specialty Pharmacy Drug to you or your Doctor. When you order a Specialty Pharmacy Drug for home or Doctor office use, you will need to pay the appropriate Deductible, Coinsurance and/or Copayment for each Specialty Pharmacy Drug by check, money order, credit card or debit card and provide all necessary information. For refills after that you will be contacted by your care coordinator.

If you or your Provider believes that you should not be required to get your Specialty Pharmacy Drugs from a Specialty Pharmacy, you must follow the exception process which is available from Our Member Services or at www.anthem.com/CUHealthPlan.

Mandatory Mail Order Pharmacy for Maintenance Drugs

You may also purchase your maintenance medication by utilizing the University of Colorado (UCH) Mail Order Prescription Service. If you are taking Maintenance Drugs you are limited to an initial 30 day supply and up to two subsequent 30-day refills of the Maintenance Drugs from a UCHealth Retail Pharmacy or Participating Retail Pharmacy. After this 90 day period you must be using the Mandatory Mail Order Program through the UCH Mail Order Prescription Service to purchase future Maintenance Drugs. A short-term drug, like an antibiotic, would not be considered a Maintenance Drug and therefore you could fill your prescription at a local retail pharmacy. Ordering your Maintenance Drugs through the UCH Mail Order Prescription Service mandatory mail order program eliminates the need for monthly trips to the pharmacy by having your prescriptions delivered directly to your home. Outpatient Tier 4

Specialty Oral and Injectable Prescription Drugs are not available through the mandatory mail order pharmacy program.

The Mail Order Pharmacy drugs benefits available under this Booklet are managed by the University of Colorado Hospital Mail Order Prescription Service at:

University of Colorado Hospital
Mail Order Prescription Service
12605 E. 16th Avenue, Mail Stop A014
Aurora, CO 80045
Phone (720) 848-1432
Fax (720) 848-1433

A Prescription Drug must be a Legend Drug to be eligible for benefits.

To receive your maintenance medicine prescription by mail, follow these steps. You can locate the UCH Mail Order Prescription Service Form that you will need to submit on Our website at www.anthem.com/CUHealthPlan:

- Ask your doctor to prescribe a 90-day supply of your maintenance medicine plus refills (certain medications will be subject to state or federal dispensing limitations). If you need the medicine immediately, ask your doctor for two prescriptions, one to be filled right away and another to be sent to the UCH Mail Order Prescription Service; Pharmacy; and
- Mail your written prescription(s), and a check to cover the amount of your Deductible, Coinsurance and/or Copayment to the University of Colorado Hospital Mail Order Prescription Service. Credit card, money orders, debit card or checks are acceptable.

Please allow 10-14 days for processing and shipping of your order.

Helpful Tip: We suggest that you order your refill two weeks before you need it to avoid running out of your medication. Any questions concerning the mail-order program, contact University of Colorado Hospital Mail Order Prescription Service at 720-848-1432 or 1-800-941-2207 if you are outside the Denver metro area.

You will receive refill forms and a notice that shows the number of refills your doctor ordered in the package with your drugs. To order refills, you must have used 75% of your mail order prescription.

When you may need to file a claim

You may need to file your own claim if:

- The pharmacy you fill your prescriptions at is not able to file the claim electronically;
- You need to have a prescription filled before you receive your Health Benefit ID Card; or
- Your Physician increases the amount of your dosage.

Clinical Trials

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

Benefits include coverage for services 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:
 - a) The National Institutes of Health.
 - b) The Centers for Disease Control and Prevention.
 - c) The Agency for Health Care Research and Quality.
 - d) The Centers for Medicare & Medicaid Services.
 - e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
 - f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- i. The Department of Veterans Affairs.
- ii. The Department of Defense.
- iii. The Department of Energy.

- 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.

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

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

GENERAL EXCLUSIONS

This section talks about the items that are not covered. The items here are not Covered Services under this Booklet, unless otherwise stated in this Booklet or required by law. 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 "Covered Services" 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. Coverage for benefits shall meet or exceed those required by applicable insurance law, which may change from time to time.

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

1. That We, in administering the Plan, determine are not Medically Necessary. Emergency medical care is not subject to this exclusion as long as such care meets the definition of emergency medical care. See the **Emergency Care and Urgent Care** section of this Booklet;
2. Received from an individual or entity that is not a Provider, as defined in this Booklet;
3. That are Experimental/Investigational or related to such, whether incurred before, in connection with, or subsequent to the Experimental/Investigational service or supply, as determined by Us, in administering the Plan;
4. To the extent they are available as benefits through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits under this Booklet will be coordinated with such governmental units to the extent required under existing state and/or federal laws;
5. For which benefits are payable under Medicare Part A, Medicare Part B and/or Medicare Part D, or would have been payable if you had applied for Medicare Part A, Medicare Part B and/or Medicare Part D, unless otherwise specified in this Booklet or as otherwise prohibited by federal law, as addressed in the section titled **Medicare** in **ADMINISTRATIVE INFORMATION**;
6. In excess of the Maximum Allowed Amount for Medical Supplies, durable medical equipment and appliances unless otherwise specified in this Booklet;
7. Incurred before your Effective Date;
8. Incurred after the termination date of this coverage unless otherwise specified in this Booklet;
9. For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Cosmetic Services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for Surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts)), except where coverage of such procedures, services or supplies are specifically required by applicable law;
10. For services performed to maintain or preserve the present level of function or prevent regression of function for an illness, injury or condition that is resolved or stable;
11. 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;
12. Weight loss programs, whether or not they are pursued under medical or Physician's supervision, unless otherwise specified in this Booklet or for the pre-operative programs and services for Bariatric Surgery;
13. Treatment of obesity, except for the pre-operative programs and services for Bariatric Surgery and surgical treatment of morbid obesity (Bariatric Surgery);
14. For care received in an emergency room which is not Emergency Care;
15. For research studies or screening examinations, unless otherwise specified in this Booklet;
16. For stand-by charges of a Physician;
17. Immunizations for travel;
18. Routine exams and immunizations required as a condition of employment, for licensing, sport programs, insurance, church, or camp;

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

46. For personal hygiene services, self-help devices that are not medical in nature, or services and supplies for comfort and convenience;
47. For care related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy;
48. Related to alternative or complementary medicine. Services in this category include, but are not limited to, massage therapy, holistic medicine, homeopathy, hypnosis, aroma therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergal synchronization technique (BEST), biofeedback, chelating agents (except for treatment of heavy metal poisoning) and iridology;
49. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas;
50. For self-help training and other forms of non-medical self-care, unless otherwise specified in this Booklet;
51. For hair loss treatment, even if the hair loss is caused by a medical condition, except for alopecia areata or as otherwise specified in this Booklet;
52. For peripheral bone density scans;
53. For storage or other administrative costs, except when provided as part of the Inpatient Services and Human Organ and Tissue Transplant Services;
54. For medical, surgical services and appliances related to temporomandibular joint (TMJ) therapy regardless of Medical Necessity;
55. For the cost of donor sperm or donor eggs, storage costs for sperm or frozen embryos, or diagnostic tests to determine the effectiveness of a procedure designed to promote fertility or pregnancy;
56. Provided or billed by a school, halfway house, custodial care facility for the developmentally disabled, or outward bound program, even if psychotherapy is included;
57. For rolfing therapy, myotherapy or prolotherapy;
58. 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;
59. For orthotics, orthopedic shoes and arch supports (except if you are diagnosed with diabetes);
60. 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 specified in this Booklet;
61. For items usually stocked in the home for general use like Band-Aids, thermometers and petroleum jelly;
62. Language training for educational, psychological or speech delays;
63. Diversional, recreational or vocational therapies such as hobbies, arts and crafts;
64. 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;
65. For any services or supplies provided to a person not covered under the Booklet in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another women for an infertile couple);
66. For care received from an Out-of-Network Provider, except for Emergency Care, Urgent Care or as preauthorized by Us as a Covered Service;
67. Language training for educational, psychological or speech delays;
68. Diversional, recreational or vocational therapies such as hobbies, arts and crafts;
69. Cardiac rehabilitation home programs, on-going conditioning and maintenance;
70. For smoking cessation programs to help you stop smoking if the program is not affiliated with Us.;
71. Nutritional counseling services except as provided in the Booklet;
72. For services rendered by a mobile health testing lab, except for Flu Shots;
73. Providers that are not licensed by to law to provide Covered Services, as defined in the Booklet;

74. For any service that you are responsible under the terms of this Booklet to pay Deductible, Coinsurance and/or Copayment, and the Deductible, Coinsurance and/or Copayment is waived by the Provider;
75. Nutritional counseling services except as provided in the Booklet; and
76. Osteopathic manipulative therapy.

Human Organ and Tissue Transplant Services:

1. Human Organ and Tissue Transplant services that are performed at any Hospital that is not designated or approved by Us for the organ or tissue being transplanted;
2. If you are not a suitable candidate as determined by the Hospital designated and approved by Us to provide Human Organ and Tissue Transplant services;
3. For donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or for their respective family members or friends unless otherwise specified in this Booklet;
4. For any transplant, treatment, procedure, facility, equipment, drug, device, service or supply that requires federal or other governmental agency approval and such approval is not granted at the time services are provided, including any service or supply associated with or provided in follow-up;
5. For transplants of organs other than those listed in the **HUMAN ORGAN AND TISSUE TRANSPLANT** section of this 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; and
8. For non-covered transportation and lodging expenses related but not limited to the following:
 - Alcohol, tobacco, other non-food items;
 - Meals;
 - Child care;
 - Mileage within the medical transplant facility city;
 - Rental cars, buses, taxis, or shuttle services, except as specifically approved by Us;
 - Frequent Flyer miles;
 - Coupons, vouchers, or travel tickets;
 - Prepayment or deposits;
 - Services for a condition that is not directly related to, or a direct result, of, the transplant;
 - Telephone calls;
 - Laundry;
 - Postage;
 - Entertainment;
 - Interim visits to a medical care facility while waiting for the actual transplant procedure;
 - Travel expenses for donor companion/caregiver; and
 - Return visits for the donor for a treatment of a condition found during the evaluation.

Online Visits:

Non-Covered Services include, but are not limited to communications used for:

- Reporting normal lab or other test results;
- Office appointment requests;
- Billing, insurance coverage or payment questions;
- Requests for referrals to doctors outside the online care panel;
- Benefit precertification; and
- Physician to Physician consultation

Retail Pharmacy/Mail Order 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 or Non-formulary Prescription Drugs;
4. Drugs prescribed for weight control or appetite suppression;
5. Medication or preparations used for cosmetic purposes to promote hair growth, prevent hair growth, or medicated cosmetics. These included but are not limited to Rogaine®, Viniqa®, and Tretinoin (sold under such brand names as Retin-A®);
6. Drugs not approved by the FDA;
7. Any medications used to treat infertility;
8. Delivery charges for prescriptions;
9. Charges for the administration of any drug unless dispensed in the Physician'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 **RETAIL PHARMACY/MAIL ORDER PRESCRIPTION DRUGS** section;
13. Therapeutic devices or appliances, including support garments and other non-medicinal supplies (regardless of intended use);
14. 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;
15. 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, 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;
16. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) except for injectable insulin, or where applicable law requires covered of the drug;
17. Prescription Drugs, which are dispensed in quantities or refill frequency which exceed the applicable limits established by Us, at Our sole discretion;
18. Refills of prescriptions in excess of the quantity or refill frequency prescribed by the Provider, or refilled more than one year from the date prescribed;
19. Prescription Drugs dispensed for the purpose of international travel;
20. Prescription Drugs which have been obtained through a Home Health Agency;
21. Replacement of lost or stolen Prescription Drugs;
22. Maintenance drugs after a total of a 90 day supply that have been purchased an In-Network pharmacy. All maintenance drugs received after your initial 90 day supply must be purchased from the University of Colorado Hospital Mail Order Prescription Service to be covered;
23. Prescription Drugs dispensed from an Out-of-Network mail order pharmacy;
24. 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; and
25. When benefits are provided for Prescription Drugs under the **RETAIL PHARMACY/MAIL ORDER PRESCRIPTION DRUGS** section, they will not also be provided under the **PRESCRIPTION DRUGS ADMINISTERED BY A PROFESSIONAL PROVIDER** section.

Chiropractic Therapy

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

ADMINISTRATIVE INFORMATION

Premiums

How Costs are Established and Changed - As this Plan is self-funded, the Trust is responsible for paying claims covered by the Plan and responsible for paying the administrative fees to Us according to the terms of the Administrative Services Agreement. Employers may require their employees to contribute to these costs through payroll deduction.

How to File Claims

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

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

In administering benefits on behalf of the employer, We authorize payment from the Trust for the benefits described in this Booklet directly to Participating and Non-Participating Providers, when you have authorized assignment of benefits. We may require a copy of the assignment of benefits for Our records. These payments fulfill our obligation to you for those services.

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

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

Inter-Plan Programs

Out-of-Area Services - Anthem Blue Cross and Blue Shield/HMO Colorado has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of Anthem Blue Cross and Blue Shield/HMO Colorado's Service Area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Our Service Area, you will obtain care from health care Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating health care Providers. Anthem Blue Cross and Blue Shield/HMO Colorado's payment practices in both instances are described below.

This plan covers only limited health care services received outside of Our Service Area. **As used in this section, "Out-of-Area Covered Healthcare Services" include emergency and urgent care obtained outside the state of Colorado. Any other services will not be covered when processed through any Inter-Plan Programs arrangements.** These "other services" must be provided or authorized by Us before care is rendered to be covered.

BlueCard® Program - Under the BlueCard® Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, Anthem Blue Cross and Blue Shield/HMO Colorado will remain responsible for fulfilling Anthem Blue Cross and Blue Shield/HMO Colorado's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers.

The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a health care Provider participating with a Host Blue, where available. The participating health care Provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment amount, as stated in your Booklet.

Emergency Care Services - If you experience a medical Emergency while traveling outside Our Service Area, go to the nearest Emergency or Urgent Care Facility.

Whenever you access covered health care services outside Our Service Area and, if applicable, HMO Colorado's corporate parent's Service Area, and the claim is processed through the BlueCard Program, the amount you pay for covered health care services, if not a flat dollar Copayment, is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem Blue Cross and Blue Shield/HMO Colorado.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Anthem Blue Cross and Blue Shield/HMO Colorado uses for your claim because they will not be applied retroactively to claims already paid.

Federal law or the law in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, We would then calculate your liability for any covered healthcare services according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation - When Out-of-Area Covered Healthcare Services are provided by non-participating providers, the amount you pay for such services will generally be based on either the Host Blue's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable 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.

Exceptions - In certain situations, We may use other payment bases, such as billed covered charges, the payment We would make if the services had been obtained within Our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount We will pay for services rendered by nonparticipating Providers. In these situations, you may be liable 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.

If you obtain services in a state with more than one Blue Plan network, an exclusive network plan arrangement may be in place. If you see a Provider who is not part of an exclusive network plan arrangement, that Provider's service(s) will be considered Non-Network care, and you may be billed the difference between the charge and the Maximum Allowable Amount. You may call the Member Services number on your Health Benefit ID Card or go to www.anthem.com/CUHealthPlan for more information about such arrangements.

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

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

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

Anthem Blue Cross and Blue Shield/HMO Colorado Claims
P.O. Box 17849
Denver, CO 80217-0849

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

Payment in Error - If, in administering benefits on behalf of the Trust, We erroneously authorize benefit payment, We may require you, the Provider of services or the ineligible person to refund the amount paid in error. We reserve the right to correct payments made in error by offsetting the amount paid in error against new claims. We also reserve the right to take legal action to correct payments made in error.

General Provisions

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

Changes to the Booklet - For modifications due to state or federal law or regulation, We, on behalf of the Plan may amend this Booklet when authorized by the Administrative Services Agreement and one of Our officers. The Plan will notify you of such change(s) to the Plan. We or the Plan will subsequently send or make available to you any amendment to this Booklet or a new Booklet.

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

Contracting Entity - You hereby expressly acknowledge that you understand that the Booklet constitutes a contract solely between you and the Trust, and that We are administering benefits on behalf of the Trust. We are an independent corporation operating under a license from the Blue Cross and Blue Shield Association, which is an association of independent Blue Cross and Blue Shield Plans. The Blue Cross and Blue Shield Association permits Us to use the Blue Cross and Blue Shield Service Mark, and in doing so, We are not contracting as the agent of the Blue Cross and Blue Shield Association.

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

Fraudulent Acts - It is unlawful to knowingly provide false, incomplete or misleading facts or information to a company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

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 Deductible, Coinsurance and/or Copayments. This practice is usually illegal.
- Be very cautious about giving your health coverage information over the phone.

If fraud is suspected, you should contact Our Member Services department.

We reserve the right to recoup any benefit payments paid on your behalf, and/or to rescind 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; Physicians and other Providers are not Our agents or employees, and We and Our employees are not employees or agents of any of Our In-Network Providers. We have no control over any diagnosis, treatment, care or other service provided to you by any Facility or Professional Providers. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries you suffer while receiving care from any of Our In-Network Providers by reason of negligence or otherwise.

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

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

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

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

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

Medicare – Any benefits covered under both this Booklet and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Health Care Financing Administration guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Booklet provisions, and federal law. Except when federal law requires Us to be the primary payor, the benefits under this Booklet if you are age 65 and older, or if you are

otherwise eligible for Medicare, do not duplicate any benefit for which you are entitled under Medicare, including Part B and/or Part D. We will coordinate benefits with Medicare consistent with applicable law. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to the Plan, to the extent We have authorized payment for such services.

Network Adequacy – We strive to provide a Provider network in Colorado that adequately addresses your health care needs. Network Adequacy 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.

Non-Contestable - This Booklet shall not be contested, except for nonpayment of Premiums by the employer, after it has been in force for two years from its date of issue. No statement made to effect coverage under the 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 furnished to the Member making the statement or to the beneficiary of any such Member.

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

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

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

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

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

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

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

Right of Overpayment Recovery - When payment has been made in error, We will have the right to recover such payment from you or the Provider. In the event We recover a payment made in error from the Provider, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider, except in cases of fraud or where the law specifies a different period of time in which to recover payment. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

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.

We have established Recovery policies to determine which recoveries are to be pursued, when to incur costs and settle or compromise Recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the Recovery method makes providing such notice administratively burdensome.

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

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

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

Workers' Compensation

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

Services and supplies resulting from work-related illness or injury are not a benefit under this Booklet, except for corporate officers who have opted out of Workers' Compensation coverage, pursuant to state or federal law, prior to the illness or injury. This exclusion from coverage applies to expenses resulting from occupational accident(s) or sickness (es) covered under the following:

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

In administering benefits on behalf of the Plan, We will not pay benefits for services and supplies resulting from a work-related illness or injury **even if other benefits are not paid because:**

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

Automobile Insurance Provisions

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

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

How We Coordinate Benefits with Complying Policies - Your benefits under this Booklet may be coordinated with the coverages afforded by a complying policy. After any primary coverages offered by the complying policy is 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 complying policy that offers primary coverage, each will pay its maximum coverage before We are liable for any further payments.

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

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

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

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

Third Party Liability: Subrogation and Right of Reimbursement

These provisions apply when the plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the plan to exercise the plan's rights and do nothing to prejudice those rights.
- In the event that you or your legal representative fail to do whatever is necessary to enable the plan to exercise its subrogation rights, the plan shall be entitled to deduct the amount the plan paid from any future benefits under the plan.
- The plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the plan's subrogation claim and any claim held by you, the plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the plan.

Reimbursement

If you obtain a Recovery and the plan has not been repaid for the benefits the plan paid on your behalf, the plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the plan from any Recovery to the extent of benefits the plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the plan shall have a right of full recovery, in first priority, against any Recovery. Further, the plan's rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the plan immediately upon your receipt of the Recovery. You must reimburse the plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the plan.
- If you fail to repay the plan, the plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the plan has paid or the amount of your Recovery whichever is less, from any future benefit under the plan if:
 - The amount the plan paid on your behalf is not repaid or otherwise recovered by the plan; or

- You fail to cooperate.
- In the event that you fail to disclose the amount of your settlement to the plan, the plan shall be entitled to deduct the amount of the plan's lien from any future benefit under the plan.
- The plan shall also be entitled to recover any of the unsatisfied portion of the amount the plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the plan will not have any obligation to pay the Provider or reimburse you.
- The plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must notify the plan promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with the plan in the investigation, settlement and protection of the plan's rights. In the event that you or your legal representative fail to do whatever is necessary to enable the plan to exercise its subrogation or reimbursement rights, the plan shall be entitled to deduct the amount the plan paid from any future benefits under the plan.
- You must not do anything to prejudice the plan's rights.
- You must send the plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the plan if you retain an attorney or if a lawsuit is filed on your behalf.

The plan administrator has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

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; or
- Blanket coverage.

The total benefits received by you, or on your behalf, from all coverage's combined for any claim for Covered Services will not exceed 100 percent of the total covered charges.

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 reasonable and customary amount 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

- a. 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.
- b. 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.
- c. 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

- a. 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.
- b. 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.
- c. 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

- a. 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.

- b. 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.
- c. 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; or
 - (3) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).
- d. 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 Expenses 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:

- a. 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; or
 - (2) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- b. For a dependent child whose parents are divorced or separated or 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; or
 - (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:
 - (a) The plan of the custodial parent;
 - (b) The plan of the spouse of the custodial parent;
 - (c) The plan of the noncustodial parent; and then
 - (d) The plan of the spouse of the noncustodial parent.
- c. 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.
- d. 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.

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 policy 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.

Out 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.

COMPLAINTS, APPEALS AND GRIEVANCES

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. We may have also denied your request to preauthorize or receive a service or a supply. If you disagree with Our decision you can:

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

Complaints

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

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

Appeals

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

The procedure the Administrator will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, the Administrator’s notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Administrator’s determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the plan’s review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA (if applicable) if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;

- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- the Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- the Administrator may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Administrator's decision, can be sent between the Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Administrator at the phone number listed on your Health Benefit ID Card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield
Appeals Department
700 Broadway CO0104-0430
Denver, CO 80273

You must include your Member Identification Number when submitting an appeal.

Upon request, the Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

The Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the Administrator will provide you, free of charge, with the rationale.

For Out of State Appeals

You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When the Administrator considers your appeal, the Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care Provider who has the appropriate training and experience in the medical field involved in making the judgment. This health care Provider will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, the Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, the Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Administrator will include all of the information set forth in the above subsection entitled "Notice of Adverse Benefit Determination."

Voluntary Second Level Appeals

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Administrator's decision, can be sent between the Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Administrator at the phone number listed on your Health Benefit ID Card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;

- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross and Blue Shield
 Appeals Department
 700 Broadway CO0104-0430
 Denver, CO 80273

You must include your Member Identification Number when submitting an appeal.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all.

Requirement to file an Appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure, but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan.

If your health benefit Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

We reserve the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

Grievances

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

Anthem Blue Cross and Blue Shield
 Quality Management Department
 700 Broadway CO0104-0430
 Denver, CO 80273-0001

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

Legal Action

Before you take legal action on a claim decision, you must first follow the process outlined under the **Appeals** heading in this section, and you must meet all the requirements of this 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 in accordance with the requirements of this Booklet. To the extent required by applicable law, if the member has exhausted all mandatory levels of review in the **Appeals** heading in this section, the member 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.

GLOSSARY

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

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

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

Acute Care - care that is provided in an office, Urgent Care setting, Emergency room or Hospital for a medical illness, accident or injury. Acute Care may be Emergency, urgent or non-urgent, but is not primarily preventive in nature.

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

Administrative Services Agreement - the agreement among Anthem Blue Cross and Blue Shield/HMO Colorado, the Trust Committee, on behalf of the Trust, and the Regents of the University of Colorado as Plan Sponsor, regardless of how such an agreement may be titled, stating all the terms and provisions applicable to the claims payment and administration of this Plan. The final interpretation of any terms found in this Booklet is governed by this agreement.

Administrator - an organization or entity that the Trust Committee, on behalf of the Plan and Trust, contracts with to provide administrative and claims payment services under the Plan. The Administrator of this Plan is Anthem Blue Cross and Blue Shield/HMO Colorado. The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

Alcoholism Treatment Center - a Hospital or Facility, licensed by the state where the facility is located, 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 non-Hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient services primarily for but not limited to:

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

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

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

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

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

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

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

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

Anniversary Date - the annual date on which the Trust renews its coverage, July 1st.

Anthem Blue Cross and Blue Shield - Rocky Mountain Hospital Medical Service, Inc., a Colorado company doing business as Anthem Blue Cross and Blue Shield. Also referred to in this Booklet as “Anthem”, “Us”, “We” or “Our.”

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

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

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

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

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

Autism Treatment Plan - a plan for a Member by an Autism Services Provider and prescribed by a Doctor or psychologist in line with a complete evaluation or reevaluation of 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.

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

Benefit Period - Your Benefit Period is based on a benefit year and begins on the Subscriber's Effective Date, and expires on the following June 30; a new Member's Benefit Period commences on each subsequent July 1. If your coverage ends earlier, the Benefit Period ends at the same time.

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

Booklet - this document, which explains the benefits, limitations, exclusions, terms and conditions of the health benefit Plan. In the event of any discrepancy, ambiguity or conflict between the terms of the Booklet and any other Plan document, terms of the Plan Document will control.

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

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

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

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

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

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

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

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

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

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

Civil Union Partnership (Partner) - a Partner to a civil union as recognized under the laws where the Subscriber lives.

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

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 - an acronym for the Consolidated Omnibus Budget Reconciliation Act of 1985. This federal law allows individuals, in certain cases, to continue their group health insurance coverage for a specified period after termination of their employment or due to a qualifying event. COBRA shall also refer to the generally parallel continuation requirements provided under the Public Health Service Act.

Coinsurance - a provision under which you share costs with Us after the Deductible is met, according to a specific formula.

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

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

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

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

Continuation Coverage - an employer provided continuation of your health insurance coverage for those individuals not eligible for COBRA coverage, available for a specified period of time after termination of a Member's employment or due to qualifying events.

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

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

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

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

Covered Services - services, supplies or treatments which are:

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

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

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

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

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

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

Dental Services - services, supplies, appliances and related expenses for treatment of conditions related to the teeth or structures supporting the teeth, or for improving dental clinical outcomes.

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

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

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

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

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

Effective Date - the date coverage under this Booklet begins. July 1st of each year.

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

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

Experimental/Investigational -

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

xExperimental or Investigational if we determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Hospice Facility -- a Facility Provider licensed by the state where the facility is located to provide Hospice Care in this state. A Hospice is a centrally administered program of palliative, supportive and interdisciplinary team services providing physical, psychosocial, spiritual and bereavement care for the terminally ill and their families to be available 24 hours a day, 7 days a week.

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

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

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

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

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

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

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

In-Vivo - within the living body.

IUD - an acronym for intra-uterine device, a devices inserted into the uterus to prevent pregnancy.

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

Long-Term Acute Care Facility - a place that gives long-term critical care services if you have serious illnesses or injuries.

Maintenance Drugs - medications that are prescribed for chronic, long-term conditions and are taken on a regular, recurring basis. Examples of chronic conditions that may require Maintenance Drugs are high blood pressure, high cholesterol, epilepsy and diabetes.

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

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

- Normal vaginal delivery;
- Cesarean section delivery; and
- Spontaneous termination of pregnancy before full term.

Maximum Allowed Amount - The maximum amount that the Plan will allow for Covered Services the Member receives. More information can be found in the **ABOUT YOUR HEALTH COVERAGE** section under **Cost Sharing Requirements**.

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

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

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

Medical Policy 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 policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 doctors from various medical specialties including Our medical directors, doctors in academic medicine and doctors in private practice.

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

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

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

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury;
- Obtained from a Physician and/or licensed, certified or registered Provider;
- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient);

- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not 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/Investigational;
- Not primarily for you, your families, or your Provider's convenience; and
- Not otherwise subject to an exclusion under this Booklet.

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

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

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

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.

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

Nephritis - infection or inflammation of the kidney.

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

Non-Participating (Out-of-Network) Provider - a Provider defined as one of the following:

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

Services from Out-of-Network (non-Participating) providers will be denied unless for Emergency Care, Urgent Care or as pre-authorized by Us.

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

Open Enrollment - the specified time period before the Plan's Anniversary Date. During this period, you may enroll yourself and your Dependents for coverage or change coverage options.

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

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

Out-of-Network - a term for Non-Participating Providers or facilities that do not enter into a network agreement with Us. Services received from a Non-Participating Provider, usually result in a higher out-of-pocket expense to you than services rendered by a Participating Provider or are only covered under limited circumstances.

Out-of-Network (Non-Participating) Provider - a Provider defined as one of the following:

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

Services from Out-of-Network (non-Participating) providers will be denied unless for Emergency Care, Urgent Care or as pre-authorized by Us.

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.

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

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

Participating (In-Network) Provider - a Provider or facility that has entered into a network agreement with Us for this specific health benefits plan.

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

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

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

Plan - the health benefit Plan provided by the Plan Sponsor and explained in this Booklet.

Plan Document - the Plan Document and Summary Plan Description for the University of Colorado Health and Welfare Trust and Plan, and the documents incorporated therein by reference.

Pharmacy and Therapeutics (P&T) Process - a process in which health care provider including nurses, pharmacists, and physicians determine the clinical appropriateness of drugs and promote access to quality medications. The process also reviews drugs to determine the most cost effective use of benefits and advise on programs to help improve care. Our programs may include, but are not limited to, drug utilization programs, preauthorization criteria, therapeutic conversion programs, cross-branded initiatives, and drug profiling initiatives.

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

Premium, costs or fees - As used in this Booklet, unless otherwise indicated, "premium", "costs", or "fees" refer to the charges that you and/or your employer must pay to establish and maintain coverage and administrative services.

Prescription Drugs - Prescription Drugs include:

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

Formulary - a list of pharmaceutical products developed in Consultation with Physicians and pharmacists and approved for their quality and cost-effectiveness. You may view a copy of the preferred formulary drug online or request a hard copy of the list by calling Our Member Services department. The preferred formulary drug list is subject to periodic review and amendment.

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

Legend Drug - a medicinal substance, dispensed for outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to show in the label, "Caution: Federal law prohibits dispensing without a prescription." Compounded (combination) drugs, when the primary ingredient (the highest cost ingredient) is FDA-approved and requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer are considered prescription Legend Drugs. Insulin is considered a Legend Drug under this Booklet.

Maintenance Drugs - medications that are prescribed for chronic, long-term conditions and are taken on a regular, recurring basis. Examples of chronic conditions that may require Maintenance Drugs are high blood pressure, high cholesterol, epilepsy and diabetes.

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

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

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

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

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

Primary Care Provider (PCP) - an acronym for Primary Care Provider, a Professional Provider who has contracted with Us to supervise, coordinate and provide initial and basic care to you, initiate a Referral for Specialist care and maintain continuity of patient care. PCPs are internal medicine Physicians, family practice Physicians, general practitioners, pediatricians, or other providers licensed in the state where they practice and recognized by Us as PCPs.

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

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

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

Provider - a person or facility that is recognized by Us as a health care Provider and fits one or more of the following 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 - examples of inpatient and outpatient facility Provider, recognized by Us and licensed by the state or jurisdiction where services are provided as follows:

Inpatient Facility Provider

- Hospital;
- Alcoholism Treatment Center;
- Residential Treatment Center;
- Hospice Facility;
- Skilled Nursing Care Facility; and
- Alternative Care Facility.

Outpatient Facility Provider

- Dialysis center;
- Veteran's Administration or Department of Defense Hospital;
- Home Health Agency;
- Alternative Care Facility; and
- Ambulatory surgery.

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, advanced registered nurse practitioners, or as allowed by Us.

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

Examples include:

- Psychiatrist;
- Orthopedist;
- Obstetrician;
- Gynecologist; and
- Cardiologist.

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 physician assistants and nurse practitioners.

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

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

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

Recovery - Recovery is money the Member, the Member’s legal representative, or beneficiary receives whether by settlement, verdict, judgment, order or by some other monetary award or determination, from another, their insurer, or from any uninsured motorist, underinsured motorist, medical payments, 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 the **THIRD PARTY LIABILITY: SUBROGATION AND RIGHT OF RECOVERY** provisions of this Booklet.

Referral - authorization given to you to visit another Provider. A Referral is generally initiated by your PCP.

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

Residential Treatment Center - is an inpatient treatment facility where the patient resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a mental or nervous disorder or substance abuse. The facility must be licensed to provide psychiatric treatment of mental or nervous disorders or rehabilitative treatment of substance abuse according to state and local laws.

Retail Pharmacy - an establishment licensed to dispense Prescription Drugs and other medications by a licensed pharmacist or mail order service upon an authorized health care Provider’s order.

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

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

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

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

Service Area - the geographic area where We are licensed to conduct business. This Plan is only available as defined by specific zip codes.

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

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

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

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

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

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

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

Spouse - a Subscriber's legal Spouse, including Common-Law Spouse. All references to Spouse include same gender domestic partners (SGDPs) and partners in a civil union, except that SGDPs and partners in civil unions are not eligible for COBRA coverage. They are eligible for continuation coverage offered through the employer.

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

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

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

Sub-Acute Rehabilitation - inpatient rehabilitation therapy that has a duration in-between acute (short-term) and chronic (long-term) and includes a minimum of one hour of rehabilitation therapy per day, when you cannot tolerate or do not require three hours of therapy a day. Sub-Acute Rehabilitation is generally provided 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 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 Abuse - means alcoholism, drug and other substance abuse. Alcoholism and Substance Abuse are conditions brought about when an individual uses alcohol, drugs or other substances in such a manner that his or her health is impaired and/or ability to control actions is lost.

Summary of Benefits and Coverage - the document, provided separately from the Booklet, which identifies the type of coverage and Deductible, Coinsurance and/or Copayment information.

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

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

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

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

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.

UCH Mail Order Prescription Service - an establishment licensed to dispense Prescription Drugs and other medications through a mail order service upon an authorized health care Provider order.

UCHealth Retail Pharmacies –establishments licensed to dispense Prescription Drugs and other medications by a licensed pharmacist upon an authorized health care Provider’s order.

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

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

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

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

Utilization Review - a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or settings. Techniques include ambulatory review, prospective review, Second Opinion, certification, concurrent review, Care Management, Discharge Planning and/or retrospective review. Utilization Review also includes reviews to determine coverage. This is based on whether or not a procedure or treatment is considered Experimental/Investigational in a given circumstance (except if it is a specifically excluded under this Booklet), and review of your medical circumstances when such a review is necessary to determine if an exclusion applies in a given situation.

Well-Child Visit - a Physician visit that includes the following components: an age-appropriate physical exam, history, anticipatory guidance, and education (e.g., examining family functioning and dynamics, injury prevention counseling, discussing dietary issues, reviewing age-appropriate behaviors, etc.), and assessment of growth and development. For older children, a Well-Child Visit also includes safety and health education counseling.

X-ray and Radiology Services - services including the use of radiology, nuclear medicine and Ultrasound equipment to obtain a visual image of internal body organs and structures, and the interpretation of these images.

End of Booklet