Health Plan
Medicare

2020-2021
A guide to your benefits

Funded by The University of Colorado Health and Welfare Trust

Welcome

Thank you for selecting the CU Health Plan as your insurance provider. By choosing this plan, you're backed by a team dedicated to providing you with the best health coverage possible and helping you save money at a time when healthcare costs are rising. You're committed to your personal wellness, and so are we.

If you're reading this, you're probably looking for information on how your plan works. You have enrolled in a 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.

This plan is self-funded by the University of Colorado Health and Welfare Trust. That means all of the claims you make will be paid by the Trust, which is funded by contributions from you and other subscribers at the University of Colorado and CU Medicine. Anthem Blue Cross and Blue Shield/HMO Colorado (Anthem) provides administrative services for your medical benefits, including provider network contracting, member services, care management and other administrative services. Your prescription drug benefits are administered by CVS Caremark.

This booklet is a guide to your plan. Please review this document, as well as the summary of benefits on the Be Colorado website, to become familiar with your benefits, including their limitations and exclusions. Bookmark this document for quick reference when you need it. By learning how your coverage works, you'll be able to make the best healthcare decisions possible and take advantage of all the great benefits available to you.

For questions about medical coverage or how medical benefits are administered, please visit BeColorado.org or call Anthem's Member Services department. Anthem's toll-free Member Services department number is located on your Anthem Health Benefit ID Card. For questions about prescription coverage or how prescription benefits are administered please visit www.caremark.com or call the number on the back of your CVS/Caremark ID card. Thank you for selecting the CU Health Plan for your healthcare needs. We wish you good health.

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

Bending the cost curve;
over $70M in CU Health Plan savings

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.
- Your Health Benefit ID Card.

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

- The University of Colorado Health and Welfare Trust ("Trust") Plan Documents.
- The Administrative Services Agreements 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").
- The Plan Document and Summary Plan Description for the University of Colorado Health and Welfare Plan.

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 not a Medicare Supplement policy. If you are eligible for Medicare, please review the "Guide to Health Insurance for People with Medicare" available at **www.medicare.gov** or from Medicare.

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 Trust.

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.

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ABOUT YOUR HEALTH BENEFITS

Benefits under this Booklet will be the Medicare allowed amount for those services covered by Medicare up to Our Maximum Allowed Amount. Medicare is the primary payer for this Plan, and Covered Services payable under this Plan will be reduced by the amounts payable for the same expenses under Medicare Parts A and B. Members enrolled under this Booklet will be considered enrolled under Medicare Parts A and B. If the medical service or supply is not covered under Medicare then it is not a covered benefit under this Plan unless otherwise indicated.

Any preauthorization requirements will be determined by Medicare unless a service is not covered by Medicare and is covered under this Booklet. In those situations preauthorization may be required.

Preauthorization is a process We use to ensure that your 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.

Admissions for all inpatient stays and certain outpatient procedures require Preauthorization. Your 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 or outpatient procedure 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 Provider. This process facilitates your timely discharge or transfer to the appropriate level of care.

Contracted Providers will bill Us directly and accept Our Maximum Allowed Amount as payment in full. The Maximum Allowed Amount is the dollar amount approved by Us for a specific covered service. For those services not covered by Medicare but that are covered under this Booklet, you are responsible for determining if your Provider is a contracted Provider.

We 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.

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 authorize for payment from the Trust and what you are responsible for paying. You meet your Cost Sharing requirements through the payment of Deductibles, Copayments, and Coinsurance (as described below). Your Cost Sharing requirements are based on the Medicare allowed amount for services covered by Medicare up to the Maximum Allowed Amount of this Plan. For those services not covered by Medicare but that are covered under this Booklet your Cost Sharing requirements are based on Our Maximum Allowed Amount.

Maximum Allowed Amount
This section describes how We determine the amount of reimbursement for Covered Services that are covered by this Booklet, but not covered by Medicare. Reimbursement for services rendered 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.
- 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.

We will, to the extent applicable, apply claim processing rules to the claim(s) submitted for those Covered Services. These rules evaluate the claim(s) 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 professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

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 and/or Coinsurance).

We will not provide any reimbursement for non-Covered Services or services provided by a Provider who is NOT a contracted Provider. Both services specifically excluded by the terms of this Booklet and those received after benefits have been exhausted are non-Covered Services.

Under certain circumstances, if We, on behalf of the Plan, pay the Provider amounts that are your responsibility, such as Deductibles or Coinsurance, We may collect such amounts directly from you. You agree that We, on behalf of the Plan, have the right to collect such amounts from you.

Deductible
A Deductible is a specified dollar amount for Covered Services that you must pay within your Benefit Period before We reimburse for covered benefits. Deductibles do contribute toward your Out-of-Pocket Annual Maximum.

Each Member must meet a separate Deductible. A new Deductible is required for each Benefit Period.

Coinsurance/Out-of-Pocket Annual Maximum
The Out-of-Pocket Annual Maximum is designed to protect you from catastrophic health care expenses. You must first meet your required Benefit Period Deductible. After the Deductible is met We authorize payment from the Plan of a percentage of charges for Covered Services. This percentage is called Coinsurance. You pay the Coinsurance percentage for Covered Services until the Out-of-Pocket Annual Maximum is reached for your Benefit Period. Until the Out of Pocket Annual Maximum is reached, you pay the remaining percentage. Once the Out-of-Pocket Annual Maximum is reached, the Plan pays 100 percent of any remaining eligible charges for the remainder of your Benefit Period.

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.

MEMBERSHIP

Subscriber

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

To qualify for benefits, you must:

- Be a resident of the United States.
- Be a retired non-PERA faculty employee.
- Be a retired non-PERA exempt professional employee.
- Be a retired University of Colorado officer in PERA who was a subscriber on July 1, 2009.
- Be eligible and enrolled under Medicare Parts A and B.

In addition, only your Medicare eligible Dependents will be eligible for benefits under this Booklet.

Dependents

A Subscriber's Medicare eligible Dependents may include the following:

- **Legal Spouse**, As defined by your employer.

- **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), 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 or a partner's child through the calendar month in which the child turns 27. A Dependent child of a Subscriber who is no longer eligible for coverage may be eligible for continuation coverage. Please contact your employer for information.

- **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 coverage 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 to the employer and evidence of court appointment as having parental responsibility or documents evidencing a legal adoption.

Enrollment Process

For eligible Subscribers and their Medicare eligible Dependents to participate in the Plan, the Subscriber must follow his/her employer's enrollment process, which details who is eligible and which 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 Spouse/Partners and their dependents using the contacts below:
  - University of Colorado – Employee Services
  - University Physicians, Inc. – Human Resources

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 paid to 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 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 notification to cancel coverage or Plan participation for any Member, coverage will end at the end of the month following notification or at the end of the month of the qualifying event. 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 an employer required Benefits Enrollment/Change Form or online submission. The Effective Date of the change will be 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.
- 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 coverage 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.

COVERED SERVICES

Any benefits payable under this Booklet for you and your Medicare eligible Dependent will be reduced by the amounts payable for the same expense under Medicare Parts A and/or B. This means Medicare will pay their benefits first and will be the primary payer of benefits. Covered Services and supplies are only benefits if they are Medically Necessary or preventive, not otherwise excluded under this Booklet as determined by Us in administering the Plan, and obtained in the manner required by this Booklet.

All benefits are subject to Medicare allowable covered guidelines which are described below. 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.

If Medicare covers the service or supply the allowance will be determined by Medicare. If the provider accepts Medicare assignment, you are not responsible for any amounts that are more the allowance Medicare allows. If Medicare does not cover a service or supply, then it is not a covered service except as provided below and it is subject to the terms of the this Booklet.

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

If Medicare does not cover a service or supply, then it is not a covered service except as provided below. Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Booklet.

- Child Health Supervision Services and immunizations.
- Shingles immunizations.
- One routine screening mammogram is covered per Benefit Period regardless of age or in accordance with the frequency determined by your Provider.
- One routine prostate specific antigen (PSA) blood test and digital rectal examination are covered per Benefit Period regardless of age or in accordance with the frequency determined by your Provider.
- Routine colorectal cancer examination and related laboratory tests are covered in accordance with the frequency determined by your Provider. A colonoscopy that is non-screening is covered as a surgical procedure and is not part of the Preventive Care Services section.

Coverage for benefits in this section shall meet or exceed those required by federal or state law.

Maternity Services and Newborn Care

If Medicare does not cover a service or supply, then it is not a covered service except as provided below. 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 48 or 96 hours timeframe.

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

- In the opinion of the attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based on evaluation of:
  - the antepartum, intrapartum, and postpartum course of the mother and newborn infant.

- the gestational stage, birth weight, and clinical condition of the infant born.
- the demonstrated ability of the mother to care for the infant after discharge.
- 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 you 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.
- 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.

Abortion Services
Benefits include services for a therapeutic abortion, which is an abortion recommended by a Doctor, performed to save the life or health of the mother, or as a result of incest or rape.

Diabetes Management Services

If Medicare does not cover a service or supply, then it is not a covered service except as provided below. 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.
- Provided by a Health Care Professional who is certified, registered or licensed with expertise in diabetes.

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

Emergency Care

If Medicare does not cover a service or supply, then it is not a covered service except as provided below. 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*.
- You will receive an Explanation of Benefits form.

Therapy Services

If Medicare does not cover a service or supply, then it is not a covered service except as provided below. Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Booklet.

From the Member's birth until the Member's sixth (6^{th}) birthday, benefits are allowed up to 20 visits each 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.

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*.

Home Care Services

If Medicare does not cover a service or supply, then it is not a covered service except as provided below. 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 on the *Summary of Benefits and Coverage* when provided by a Home Care Agency).
- Medical and Surgical Supplies.
- Durable Medical Equipment.
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).

Medical Foods

If Medicare does not cover a service or supply, then it is not a covered service except as provided below. Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Booklet.

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

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

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

Hospice Care

If Medicare does not cover a service or supply, then it is not a covered service except as provided below. 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.
- 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.

Medical Supplies, Durable Medical Equipment, and Appliances

If Medicare does not cover a service or supply, then it is not a covered service except as provided below. Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Booklet.

Prosthetic Devices

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

- Replace all or part of a missing body part and its adjoining tissues.
- 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.

Hearing Aid Services

If Medicare does not cover a service or supply, then it is not a covered service except as provided below. Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Booklet. The following hearing aid services are covered up to the 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.
- 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.
- Visits for fitting, counseling, adjustments and repairs after receiving the covered hearing aid.

Dental Related Services

If Medicare does not cover a service or supply, then it is not a covered service except as provided below. Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Booklet.

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

If Medicare does not cover a service or supply, then it is not a covered service except as provided below. 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.
- 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 the "Prescription Benefits Administered by CVS Caremark" section.

Prescription Benefit Administered by CVS Caremark

If Medicare does not cover a service or supply, then it is not a covered service except as provided below. Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Booklet.
If you enroll in medical coverage, you automatically receive prescription drug benefits administered by CVS Caremark.

How Prescription Drug Benefits Work

To be eligible for coverage, a prescription drug must be:

- Necessary for the treatment of a disease or illness and widely accepted as effective, appropriate and essential – based on the recognized standards of the medical community,
- Prescribed by a licensed physician and
- Prescribed in accordance with type, frequency and duration-of-treatment guidelines of national medical, research and governmental agencies.

Visit the CVS Caremark website (www.caremark.com) or call CVS Caremark at 1-888-964-0121 for the generic, brand, (preferred or non-preferred) and specialty listing that describes those prescription drugs that are eligible and ineligible for reimbursement under your CU Health Plan. If you have any questions about a particular prescription, call CVS Caremark. The fact that your physician prescribes, orders, recommends, or approves a prescription or supply does not automatically mean it is an eligible expense. Always call CVS Caremark to confirm coverage.

The program offers coverage for both your short-term and long-term prescription needs. To receive prescription drug benefits, you and your covered dependents may pay a portion of the covered expenses for prescription drugs and related supplies. That portion is the copayment, deductible or coinsurance.

The CVS Caremark network includes many retail pharmacies, including major chain pharmacies and independent community pharmacies. To locate a participating pharmacy either call CVS Caremark directly at 1-888-964-0121. To find the pharmacy closest to you, go to www.caremark.com.

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 any Deductible and/or Coinsurance. 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.

This section describes the outpatient pharmacy benefits for medications obtained through a Retail Pharmacy, University of Colorado Hospital (UCH) Mail Order Prescription Service, or CVS Mail Order Pharmacy.

Outpatient Pharmacy services do not include services received in the Hospital as an Inpatient. For Medical Supply, durable medical equipment or appliance not obtained through a pharmacy, see the **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES** section of this Booklet.

You may fill your prescriptions through any pharmacy. Mail order prescriptions may be filled by the University of Colorado Hospital (UCH) Mail Order Prescription Service or through CVS Mail Order Pharmacy.

For mail order Prescription Drugs they must be on the formulary drug list to be eligible for benefits. You may check your drug coverage by calling CVS Caremark customer service with the number on the back of you ID card or by referencing the Check Drug Cost tool on www.caremark.comThe formulary drug list is subject to quarterly review and amendment. Inclusion of a drug or related item on the preferred formulary drug list is not a guarantee of coverage.

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

Certain prescription drugs (or the prescribed quantity of a particular drug) may require Preauthorization. At the time you fill a prescription, the pharmacist is informed of the Preauthorization requirement through the pharmacy's computer system, and the pharmacist is instructed to contact Our contracted pharmacy affiliate. You may check your drug coverage and prior authorization requirements by calling CVS/caremark customer service with the number on the back of you ID card or by referencing the Check Drug Cost tool on www.caremark.comOutpatient pharmacy benefits 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 cost share. Please contact customer service or visit **www.caremark.com** for additional information.
- Oral contraceptive drugs and contraceptive devices.
- 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.
- 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 filled at a Retail Pharmacy is subject Deductible and Coinsurance.

Your Deductible 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.

Tier-4 – Specialty Drugs

See the *Summary of Benefits and Coverage* to determine the associated Cost share for each tier.

You are limited to a 90-day supply of a prescription drug if obtained at a Retail Pharmacy or received through a mail order service. For oral contraceptives, you are limited to three pill packs (normally 84 days) at a pharmacy, or three pill packs by mail order. When Medically Necessary, a one-month vacation override is available with applicable Deductible and/or Coinsurance and with quantity restrictions if you are traveling out of Colorado.

University of Colorado Hospital (UCH) Mail Order Prescription Service for Maintenance Drugs

You may purchase your maintenance medication by utilizing the University of Colorado Hospital (UCH) Mail Order Prescription Service and have your prescription delivered directly to your home. The University of Colorado Hospital Mail Order Prescription Service is located 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.

You can locate the University of Colorado Hospital (UCH) Mail Order Prescription Service Form that you will need to submit at www.uchealth.org/services/pharmacy. Any questions concerning the mail-order program through the University of Colorado Hospital, contact University of Colorado Hospital Mail Order Service at 720-848- 1432or 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.

CVS Caremark Home Delivery Pharmacy (Mail Order)

You may also purchase your Maintenance Drugs by utilizing the CVS Caremark Mail Order Pharmacy and have your prescription sent directly to your home.

To get started with Mail Order, contact us at the number on the back of your ID card or visit www.caremark.com to get started. You can easily manage refills and check order status.

You will receive refill forms and a notice that shows the number of refills your Doctor ordered in the package with your drugs.

Placing Mail Order/Home Delivery Pharmacy Orders

To receive your Maintenance Drugs by mail, follow these 3 steps:

- Ask your Doctor to write a prescription for a 90-day supply of your drugs plus three refills (certain medications may be subject to state or federal dispensing limitations). If you need the drugs right away, ask your Doctor for two prescriptions, one to be filled right away at a Retail Pharmacy and another to be sent to the Home Delivery/Mail Order Pharmacy.
- Complete any order form which is required by the In-Network Mail Order /Home Delivery Pharmacy.

Please allow 7-14 days for processing and shipping of your order. To order refills, you must have used 75% of your home delivery prescription.

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

Helpful Tip: We suggest that you order your refill two weeks before you need it to avoid running out of your drugs. Any questions concerning the UCH Mail Order Prescription Service or CVS Caremark Mail Order, contact Member Services.

When you may need to file a claim for Retail, Specialty or Mail Order/Home Delivery Pharmacy Drugs

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.
- Your Physician increases the amount of your dosage.

Clinical Trials

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

GENERAL EXCLUSIONS

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

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

1. That We, 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 federal laws.
5. For which benefits are payable under Medicare Part A and/or Part B, unless otherwise specified in this Booklet.
6. In excess of the Maximum Allowed Amount.
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 care received in an emergency room which is not Emergency Care.
11. Immunizations for travel.
12. Routine exams and immunizations required as a condition of employment, for licensing, sport programs, insurance, church, or camp.
13. For Private Duty Nursing Services, except when provided through the Home Care Services or Hospice Care Services sections of this Booklet.
14. 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.
15. 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.
16. For complications arising from non-Covered Services and supplies.
17. Services not specifically listed in this Plan as Covered Services.
18. 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.
19. 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.
20. For a condition resulting from a riot, civil disobedience, nuclear explosion or nuclear accident.

21. For which you have no legal obligation to pay in the absence of this or like coverage.
22. Prescribed, ordered or referred by, or received from, a member of your immediate family (parent, child, Spouse, sister, brother or self).
23. For completion of claim forms or charges for medical records or reports, unless otherwise required by law.
24. For missed or canceled appointments.
25. For mileage costs or other travel expenses, except as preauthorized by Us, in administering the Plan.
26. For eyeglasses, contact lenses or their fitting, vision therapy or routine vision exams, unless otherwise specified in this Booklet.
27. For hearing aid services, unless otherwise specified in this Booklet.
28. For smoking cessation programs to help you stop smoking if the program is not affiliated with Us.
29. 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.
30. For items usually stocked in the home for general use like Band-Aids, thermometers and petroleum jelly.
31. Providers that are not licensed by to law to provide Covered Services, as defined in the Booklet.
32. For any service that you are responsible under the terms of this Booklet to pay a Copayment, Deductible or Coinsurance, and the Copayment, Deductible or Coinsurance is waived by the Provider.
33. Nutritional counseling services except as provided in the Booklet.
34. Care for services outside of the United States except for Emergency care needed to medically stabilize the member for the purpose of travel back to the United States.
35. Abortions Services, supplies, Prescription Drugs, and other care for elective (voluntary) abortions and/or fetal reduction surgery. This Exclusion does not apply to therapeutic abortions, which is an abortion recommended by a Doctor, performed to save the life or health of the mother, or as a result of incest or rape.
36. Aids for non-verbal communication which include but are not limited to, devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by Us.
37. Acupressure to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body, except as specifically listed as a Covered Service.
38. Autopsies and post-mortem testing.
39. Any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this coverage for non-Investigational treatments.
40. Charges associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing.
41. Dental devices for snoring including oral appliances for snoring.
42. Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

43. Home Health Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Agency. Home Health Services for food, housing, homemaker services and home delivered meals.

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

45. Medical and surgical treatment of excessive sweating (hyperhidrosis).

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

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

48. Temporomandibular joint treatment for fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (implants, crowns, bridges, dentures).

49. Wilderness or other outdoor camps and/or programs.

Retail Pharmacy/Mail Order Prescription Drugs:

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

1. 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.

2. Non-legend prescription drugs.

3. 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 finasteride.

4. Any drug, product or technology within six (6) months of Food and Drug Administration (FDA) approval. We may, at Our sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology.

5. Any medications used to treat infertility.

6. Delivery charges for prescriptions.

7. Charges for the administration of any drug unless dispensed in the Physician's office or through Home Health Care.

8. Drugs which are provided as samples to the Provider.

9. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse.

10. 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 DRUG** section.

11. Therapeutic devices or appliances, including support garments and other non-medicinal supplies (regardless of intended use).
12. 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.

13. 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.

14. 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 coverage of the drug.

15. Prescription drugs, which are dispensed in quantities or refill frequency which exceed the applicable limits established by Us, at Our sole discretion.

16. Refills of prescriptions in excess of the quantity prescribed by the Provider, or refilled more than one year from the

date prescribed.

17. Prescription Drugs dispensed for the purpose of international travel.

18. Prescription Drugs which have been obtained through a Home Health Agency.

19. Drugs for treatment of sexual or erectile dysfunction or inadequacies, regardless of origin or cause, and even if the dysfunctions a side effect of, or related to another covered disease or illness.

ADMINISTRATIVE INFORMATION

Premiums

How Costs are Established and Changed - As this Plan is self-funded, the Plan 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 of the Trust may require their employees to contribute to these costs through payroll deduction.

How to File Claims

For services not covered by Medicare that are covered under this Booklet, when a PPO or Participating Provider bills Us for Covered Services, We will authorize payment from the Plan of the appropriate charges for the benefit directly to the Provider. You are responsible for providing the PPO or Participating Provider with all information necessary for the Provider to submit a claim. You pay the applicable Deductible and/or Coinsurance to the Provider when the Covered Service is received.

If a Non-Participating 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 web site 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.

You have coverage for emergency medical services to make you medically stable when travelling outside the United States. You will need to file a claim form for Covered Services. All information on the claim form and itemized bill must be readable. 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 States 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.

You authorize Us to make payments directly to Providers for Covered Services. In no event, however, shall Our right to make payments directly to a Provider be deemed to suggest that any Provider is a beneficiary with independent claims and appeal rights under this coverage. Where permitted by applicable law, We reserve the right to make payments directly to you as opposed to any Provider for Covered Service, at Our discretion. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the Out-of-Network Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an Alternate Recipient (which is defined herein as any child of a Subscriber who is recognized under a “Qualified Medical Child Support Order” as having a right to enrollment under the Group’s Plan), or that person’s custodial parent or designated representative. Any payments made by Us (whether to any Provider for Covered Service or you) will discharge our obligation for Covered Services. You cannot assign your right to receive payment to anyone, except as required by a “Qualified Medical Child Support Order” as defined by, and if subject to, ERISA or any applicable Federal law.

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

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

A separate claim form is required for each Non-Participating 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.

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 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 a PPO or Participating Provider, claims payments will be made to the Provider.

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

Confidentiality and Release of Information - Applicable state and federal law requires Anthem to undertake efforts to safeguard the member's information.

For informational purposes only, please be advised that a statement describing Anthem's policies and procedures regarding the protection, use and disclosure of the member's medical information is available on Anthem's website and can be furnished to the member upon request by contacting the member service department.

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

Conformity with Law - any term in this Booklet which is in conflict with the laws of the state in which the Group Contract is issued, or with federal law, will hereby be automatically amended to conform 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 Plan, and that we are administering benefits on behalf of the Plan. 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.

Independent Contractors - We have an independent contractor relationship with Our Participating 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 Participating 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 Participating 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 Substance Abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims payment or Member Services duties on Our behalf.

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

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

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

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

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.becolorado.org/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.

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

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

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.
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 thess addresses as explained under the **Appeals** heading in this section:

For Medical Services:

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

For Prescription Services:

Prescription Claim Appeals MC 109 - CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax: 1-866-443-1172

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 as explained under the **Appeals** heading at these addresses::

For Medical Services:

HMO Colorado
Member Services Department
P.O. Box 17549
Denver, CO 80217-0549

For Prescription Services:

Prescription Claim Appeals MC 109 - CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax: 1-866-443-1172

Medical 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.
- 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.
- information regarding your potential right to an External Appeal pursuant to federal law.

For claims involving urgent/concurrent care:

- the Administrator's notice will also include a description of the applicable urgent/concurrent review process.
- 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.
- 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
HMO Colorado
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.
- was submitted, considered, or produced in the course of making the benefit determination.

- 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.
- 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.
- 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
HMO Colorado
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 parties except for any relief available through applicable state laws or ERISA (if applicable).

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 one year 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 within one year of the decision.

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.

Prescription Appeals

Once a member or member's representative is notified that a claim is wholly or partially denied (an adverse determination), he or she has the right to appeal. Appeals may be based on an adverse benefit determination from an initial clinical review or an adverse non-clinical determination from an initial non-clinical review. Appeal requests must be submitted to the Appeals department by fax, mail or phone within 180 days after receiving an adverse determination notification. Urgent appeals may be submitted by phone or in writing. Non-urgent appeals may be submitted in writing by fax or mail.

Once an appeal is received, the appeal and all supporting documenting are reviewed and completed, including a notification to the member and physician, within the following timelines:

- Urgent Pre-Service Appeal: 72 hours
- Non-Urgent Pre-Service Appeal: 15 days
- Post-Service Appeal: 30 days

Review of Adverse Benefit Determinations
First-Level Clinical Appeal

First-level appeals are reviewed against predetermined medical criteria relevant to the drug or benefit being requested. This includes the consideration of relevant and supporting documentation submitted by the member or the member's authorized representative. Supporting documentation may include a letter written by the practitioner in support of the appeal, a copy of the denial letter sent by CVS Caremark, a copy of the member's payment receipt, medical records, etc. The appeal will be reviewed by an appropriately qualified reviewer. If the denial is upheld by the appeal, a denial notification will be sent to the member with instructions on how to request a second-level Medical Necessity review.

If a member's appeal is urgent, CVS Caremark will perform both the first-level and second-level review as a combined

appeal review within the designated timeframes. If the first-level request is approved, no further review is required and a notice of approval will be sent to the member. If the first-level review cannot be approved, a second-level Medical Necessity review will be initiated automatically. The member will receive notice of the determination at the conclusion of the Medical Necessity review. The two levels are combined in order to meet the designated urgent appeal timeframe.

Second-Level Medical Necessity Appeals

If the first-level appeal denial is upheld, the member or the member's authorized representative may choose to pursue a second-level appeal. The second-level appeal consists of a review to determine if the requested drug or benefit is medically necessary. These requests are reviewed either by an appropriately qualified reviewer or a sub-delegated medical necessity review organization (MNRO). If a member's appeal is urgent, CVS Caremark will perform the second-level review within the designated urgent appeal timeframe.

For appeals reviewed by the MNRO, the following will occur:

- CVS Caremark will forward applicable medical records, PA and appeals documentation, plan language and specific criteria to the MNRO.
- The independent physician reviewer selected by the MNRO to conduct the review will evaluate the provided documentation received with the case. If the physician reviewer determines additional information is necessary or potentially useful in the review, the physician reviewer may contact the member's physician to request such information.
- The independent physician reviewer will review current medical literature and available medical records and any additional information obtained from the prescribing physician. The independent physician reviewer will write an independent rationale in support of his or her final decision.
- The letter containing the rationale will be forwarded to CVS Caremark for communication to the member or the member's representative.

Review of Adverse Non-Clinical Determinations

CVS Caremark provides a single-level appeal for non-clinical appeals. Upon receipt of a non-clinical appeal, CVS Caremark will review the member's request for a particular drug or benefit against the terms of the Plan, including the preferred drug lists, formularies or other defined plan benefits selected by the Plan Sponsor or in the PDD. A non-clinical appeal will not involve an assessment of whether the requested drug or benefit is medically necessary.

Appeal Determination Process

Appeals and associated documentation are stamped with the date and time of receipt. Reviews are conducted within the applicable timeframes previously mentioned in this document. The appeal determination is rendered, and pertinent information is entered into the database. The determination is then communicated in writing to the member or the member's representative.

Communications are written in a manner to be understood by the member or the member's representative. Communications include:

- The specific reason(s) for the determination
- A reference to pertinent Plan provision on which the determination was based
- A notice that the member can submit a written request for the following at no cost: copies of all documents, records and other information relevant to the claim
- A copy of the specific rule, guideline, protocol or other similar criterion that was relied upon in making the determination, if applicable; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request
- An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the member's medical circumstances, if the Adverse Benefit Determination or Appeal of Adverse Benefit Determination is based on a Medical Necessity; or a statement that such explanation will be provided free of charge upon written request

- A statement of the member's right to bring action under (Employee Retirement Income Security Act) ERISA Section 502(a), if applicable

- A description of the available internal appeals process and external review process, if available • Information regarding the applicable office of health insurance consumer assistance or ombudsman established under the Section 2793 of the Public Health Services Act to assist individuals with internal claims and appeals and external review

Confidentiality

All member and client appeal documentation is handled in a confidential manner and in accordance with applicable statutes and regulations to protect the member's identity and his or her prescription history. To maintain confidentiality of member information, all appeal information becomes a part of a permanent case file.

Grievances

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

For Medical Services:

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

For Prescription Services:

Prescription Claim Appeals MC 109 - CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax: 1-866-443-1172

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 a 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.

Administrative Services Agreement — the agreements among Anthem Blue Cross and Blue Shield, CVS Caremark, the Trust Committee, on behalf of the Trust, and the 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.

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

Alcohol Abuse -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.

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 Plan renews its coverage.

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", as applicable to medical services

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

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 Booklet will control.

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.

Complaint — an expression of dissatisfaction with Our services or the practices of a Participating 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.

Cost Sharing - the general term used for out-of-pocket expenses you pay, e.g. Deductibles and Coinsurance 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.
- 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.

CVS Caremark – the prescription benefit manager for this plan. Also referred to in this Booklet as "CVS", "Us", "We" or "Our", as applicable to prescription services.

Deductible - an amount that is required to be paid by you before We will begin to reimburse for Covered Services. Some Covered Services have a maximum benefit of days or visits 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.

Dependent - a Subscriber's spouse, partner, or child as defined by the employer and in the **MEMBERSHIP** section of this Booklet under the heading **Dependents**.

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

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.

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

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

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

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

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

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

- Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal.
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies.
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.

- Documents of an IRB or other similar body performing substantially the same function.

- Consent documentation(s) used by the treating Physicians, other medical professionals or facilities, or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
- The written protocol(s) used by the treating Physicians, other medical professionals or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply.
- Medical records.
- The opinions of consulting Providers and other experts in the field.

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

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.

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

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

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

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

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

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

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

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.

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.
- 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 are also 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.

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.

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

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 this Plan is self-funded, insurance premiums are not paid by the member. As used in this Booklet, unless otherwise indicated, "premium", "costs", or "fees" refer to the charges that the Plan 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.

Generic Prescription 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.

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

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.

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

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.
- Alternative Care Facility.

Outpatient Facility Provider

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

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 professional's order.

Spouse - a Subscriber's spouse/partner, as defined by the employer. Partners may not be eligible for COBRA coverage, but may be 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.
- 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.

Subcontractor - We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs and Mental Health and Substance Abuse services. Such subcontracted organizations or entities may make benefit determinations and/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. 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 and found in the front of the Booklet, which identifies the type of coverage and Deductible and Coinsurance information.

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 professional's order.

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

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).

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.

End of Booklet

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Albanian

Keni të drejtën të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për ndihmë, telefononi numrin e shërbimeve për anëtarët, të shënuar në kartën tuaj ID. (TTY/TDD: 711)

Amharic

ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።(TTY/TDD: 711)

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711.)

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Bassa

Ǹ ɓéɖé dyí-ɓèɖɛ̀ìn-ɖèɔ̀ ɓé m̀ ké bɔ̌ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn bó pídyi. Ɖá méɓà jè gbo-gmɔ̀ Kpòè nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̂ɔ̃ kɔ̃ɛ ɓé m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Bengali

আপনার বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন।(TTY/TDD: 711)

Burmese

ဤအချက်အလက်များနှင့် အကူအညီကို သင့်ဘာသာစကားဖြင့် အခမဲ့ ရပိုင်ခွင့် သင့်တွင်ရှိပါသည်။ အကူအညီ ရယူရန် သင့် ID ကဒ်ပေါ်ရှိ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန၏ နံပါတ်သို့ ခေါ်ဆိုပါ။

(TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Dinka

Yin nɔŋ yic ba ye lëk në yök ku bë yi kuɔny në thöŋ yin jäm ke cin wëu töu kë piiny. Cɔl rän töŋ dë kɔc kë luɔi në nämba dën tö në I.D kat du yic. (TTY/TDD: 711)

Dutch

U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel het ledendienstennummer op uw ID-kaart voor ondersteuning. (TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید.(TTY/TDD: 711)

French

Vous avez le droit d’accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d’identification. (TTY/TDD: 711)

German

Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Greek

Έχετε το δικαίωμα να λάβετε αυτές τις πληροφορίες και αυτήν τη βοήθεια στη γλώσσα σας δωρεάν. Καλέστε τον αριθμό του Τμήματος Υπηρεσιών Μέλους (Member Services) που αναγράφεται στην ταυτότητά σας (ID card) για βοήθεια. (TTY/TDD: 711)

Gujarati

તમે તમારી ભાષામાં મફતમાં આ માહિતી અને મદદ મેળવવાનો અધિકાર ધરાવો છો. મદદ માટે તમારા આઇડી કાર્ડ પરના મેમ્બર સર્વિસ નંબર પર કોલ કરો. (TTY/TDD: 711)

Haitian

Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Igbo

Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Ilokano

Addanka ti karbengan a maala iti daytoy nga impormasyon ken tulong para ti lengguahem nga awanan ti bayadna. Awagan ti numero ti Serbisyo para ti Kameng a masarakan ayan ti ID kard mo para ti tulong. (TTY/TDD: 711)

Indonesian

Anda berhak untuk mendapatkan informasi ini dan bantuan dalam bahasa Anda secara gratis. Hubungi nomor Layanan Anggota pada kartu ID Anda untuk mendapatkan bantuan. (TTY/TDD: 711)

Italian

Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer

អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។ (TTY/TDD: 711)

Kirundi

Ufise uburenganzira bwo gufashwa mu rurimi rwawe ku buntu. Akura umunywanyi abikora Ikaratakarangamuntu yawe kugira ufashwe. (TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Lao

ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນ ແລະ ຄວາມຊ່ວຍເຫຼືອປ້ນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາເບີໂທຂອງຜ່ຍບໍລິການສະມາຊິກທີ່ໃຫ້ໄວ້ໃນບັດປະຈຳຕົວຂອງທ່ານເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. (TTY/TDD: 711)

Navajo

Bee n1 ahoot'i' t'11 ni nizaad k'ehj7 n7k1 a'doowo[t'11 j77k'e. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. Naaltsoos bee atah n7l7n7g77 bee n44ho'd0lzingo nanitin7g77 b44sh bee hane'7 bik11' 1aj8' hod77lnih. (TTY/TDD: 711)

Nepali

तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्।(TTY/TDD: 711)

Oromo

Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Pennsylvania Dutch

Du hoscht die Recht selle Information un Helfe in dei Schprooch mitaus Koscht griege. Ruf die Member Services Nummer uff dei ID Kaarte fer Helfe aa. (TTY/TDD: 711)

Polish

Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Portuguese-Europe

Tem o direito de receber gratuitamente estas informações e ajuda no seu idioma. Ligue para o número dos Serviços para Membros indicado no seu cartão de identificação para obter ajuda. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Romanian

Aveți dreptul să obțineți aceste informații și asistență în limba dvs. în mod gratuit. Pentru asistență, apelați numărul departamentului de servicii destinate membrilor de pe cardul dvs. de identificare. (TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Samoan

E iai lou ‘aia faaletulafono e maua nei faamatalaga ma se fesoasoani i lou lava gagana e aunoa ma se totogi. Vili le numera mo Sauniuniga mo lou Vaega o loo maua i lou pepa faailoa ID mo se fesoasoani. (TTY/TDD: 711)

Serbian

Imate pravo da dobijete sve informacije i pomoć na vašem jeziku, i to potpuno besplatno. Pozovite broj Centra za podršku članovima koji se nalazi na vašoj identifikacionoj kartici. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ (TTY/TDD: 711)

Ukrainian

Ви маєте право безкоштовно отримати інформацію та допомогу своєю рідною мовою. По допомогу звертайтеся за номером служби підтримки учасників програми страхування, указаним на вашій ідентифікаційній картці. (TTY/TDD: 711)

Urdu

آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔(TTY/TDD:711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yiddish

רופט די מעמבער באדינונגען נומער אויף איר האט די רעכט צו באקומען דעם אינפארמאציע און הילפט אין אייער שפראך בחינם. (TTY/TDD:711אייער קארטל פאר הילף)

Yoruba

O ní ẹtọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)

It's important we treat you fairly

That's why University of Colorado Health and Welfare Plan follows federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160,Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

The University of Colorado, as Plan Sponsor of the University of Colorado Health and Welfare Plan ("the University"), complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The University does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The University provides free aids and services to people with disabilities to communicate effectively, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). The University also
provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the HIPAA Privacy Officer with CU Health Plan Administration.

If you believe that the University has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

HIPAA Privacy Officer
CU Health Plan Administration
1999 Broadway, Suite 820
Denver, CO 80202
(303) 860-4199
(303) 860-4177 (fax)
cuhealthplan@cu.edu

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the HIPAA Privacy Officer with CU Health Plan Administration is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at
https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.