A Guide to Your Benefits

You've made a good decision in choosing
The UA Net Plan for the University of Colorado

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An Anthem Company

Colorado Health Benefit Plan Description Form
UA Net Plan for the University of Colorado

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	UA Net Plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Only for emergency
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

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

	IN-NETWORK THROUGH UA NET PROVIDERS ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4. DEDUCTIBLE TYPE[2]	Benefit Year
4a. ANNUAL DEDUCTIBLE[2a] a) Individual[2b] b) Family[2c]	 No deductible No deductible
5. OUT-OF-POCKET MAXIMUM[3] a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	 Unlimited Unlimited Not applicable
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum for most covered services. Infertility diagnostic services have a lifetime maximum payment of $2,000 per member. Major organ transplants have a lifetime maximum benefit of $1,000,000 per transplant per member.
7A. COVERED PROVIDERS	UA Network Managed Care Network. This is a limited provider network. See provider directory at www.anthem.com/universityofcolorado for complete list of current providers.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes

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

	IN-NETWORK THROUGH UA NET PROVIDERS ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
8. MEDICAL OFFICE VISITS[4]	
a) Primary Care Providers	$30 copayment per visit
b) Specialists	$40 copayment per visit
9. PREVENTIVE CARE	
a) Children's services	$15 copayment per visit
b) Adults' services	$15 copayment per visit
c) Colorectal screening services[4a, 4b]	$15 copayment per visit. For non-preventive colonoscopies and sigmoidoscopies coverage is provided under line 13 below.
10. MATERNITY	
a) Prenatal care	$15 copayment, one copayment per pregnancy
b) Delivery & inpatient well baby care[5]	$250 copayment per day up to a maximum of $1,000 in copayments per admission

	IN-NETWORK THROUGH UA NET PROVIDERS ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions[6] a) Inpatient care	Included with the inpatient hospital copayment (see line 12)
b) Outpatient care **University of Colorado Hospital (UCH) Retail Pharmacy Locations** Atrium Pharmacy 12065 E 16th, Room 1054, MS A027 Aurora, CO 80045 Phone (720) 848-4083 Fax (720) 848-4084 Anschutz Outpatient Pavilion (AOP) Pharmacy 1635 Aurora Court, RM 1012, MS F702 Aurora, CO 80045 Phone (720) 848-1020 Fax (720) 848-1040 Garfield Pharmacy at Lowry 8011 E Lowry Blvd., STE 110, MS B01, Denver, CO 80230 Phone (720) 848-9590 Fax (720) 848-9593	Tier 1 generic prescription $12.50 copayment for 30-day supply and $25 for 90 day supply, tier 2 brand-name prescription $30 copayment for 30- day supply and $60 for 90-day supply. Copayments apply to retail purchases at UCH pharmacies.
Anthem Participating Retail Pharmacy Locations	Tier 1 generic prescription $15 copayment, Tier 2 brand-name prescription $35 copayment, Tier 3 non-formulary prescription **not** covered, per prescription at a Anthem participating pharmacy up to a 30-day supply **After a maximum of 90 days, maintenance medications must be ordered through the University of Colorado Hospital Mail Order Prescription Service to be covered.**
c) Prescription Mail Service **Mail Order Pharmacy Location** University of Colorado Hospital Mail Order Prescription Service 12065 E. 16th, Mail Stop A014 Aurora, Co 80045 Phone (720) 848-1432 Fax (720) 848-1433	Tier 1 generic prescription$25 copayment, tier 2 brand-name prescription $60 copayment, per prescription through the mail-order service up to a 90-day supply. **Only orders placed through the University of Colorado Hospital Mail Order Prescription Service will be covered.**
12. INPATIENT HOSPITAL	$250 copayment per day up to a maximum of $1,000 in copayments per admission
13. OUTPATIENT/AMBULATORY SURGERY	$250 copayment per visit
14. LABORATORY AND X-RAY a) Laboratory & x-ray	No copayment (100% covered)
b) MRI, nuclear medicine, and other high-tech services	$100 copayment per procedure for MRI/MRA/CT/PET scans
15. EMERGENCY CARE [7,8]	$150 copayment per emergency room visit. Copayment is waived if admitted. Care is covered in-network or out-of-network.
16. AMBULANCE	No copayment (100% covered). Care is covered in-network or out-of-network.

	IN-NETWORK THROUGH UA NET PROVIDERS ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$150 copayment for urgent care received in an emergency room. $30 copayment per urgent care visit at all other locations. Urgent care may be received from your PCP or from an urgent care center. Care is covered in-network or out-of-network.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	 $250 copayment per day up to a maximum of $1,000 in copayments per admission 100% Covered (Not subject to deductible, coinsurance or copayment.
20. ALCOHOL & SUBSTANCE ABUSE a) Inpatient care b) Outpatient care	 $250 copayment per day up to a maximum of $1,000 in copayments per admission 100% Covered (Not subject to deductible, coinsurance or copayment.
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY a) Inpatient b) Outpatient	 $250 copayment per day up to a maximum of $1,000 in copayments per admission. Limited to 30 non-acute inpatient days per benefit year. $30 copayment per visit. Limited to a maximum of 20 visits per certain acute conditions for physical, occupational and speech therapy. For children born with congenital defects or birth abnormalities up to age 6, 20 visits each of physical, occupational and speech therapy per benefit year.
22. DURABLE MEDICAL EQUIPMENT	No copayment (100% covered). Limited to a maximum benefit of $4,000 per benefit year; combined with oxygen (see line 23). Prosthetic appliances 20% copayment, services are not subject to the maximum benefit. Orthopedic braces and podiatric shoe inserts are limited to a separate combined $500 maximum benefit per benefit year. Surgical bras are limited to a separate combined $500 maximum benefit per benefit year. Colostomy/ostomy supplies are limited to a separate combined $3,000 maximum benefit per benefit year.
23. OXYGEN	No copayment (100% covered). Limited to a maximum benefit of $4,000 per benefit year; combined with durable medical equipment (see line 22).
24. ORGAN TRANSPLANTS	$250 copayment per day up to a maximum of $1,000 in copayments per admission
25. HOME HEALTH CARE	No copayment (100% covered)
26. HOSPICE CARE	No copayment (100% covered)
27. SKILLED NURSING FACILITY CARE	No copayment (100%) covered. Limited to 100 days per benefit year.
28. DENTAL CARE	Not covered
29. VISION CARE	$30 copayment per eye exam. Limited to a maximum of one visit every 12 months. Coverage is not provided for hardware. Additional information on the vision benefits included in this plan can be found on the separate BlueView Vision Summary Description.

	IN-NETWORK THROUGH UA NET PROVIDERS ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
30. CHIROPRACTIC CARE	$30 copayment per visit. Limited to 20 visits per benefit year.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES	Members who desire another professional opinion may obtain a second opinion. **Treatment of Autism Spectrum Disorders** Member cost shares and benefit level determined by type of service provided. The following annual maximums, based on benefit year, are effective for applied analysis services: • Birth to age eight (up to member's ninth birthday): $34,000 • Age nine to age eighteen (up to member's nineteenth birthday): $12,000 **Hearing Aids for Children**[12] Benefit level determined by place of service. Hearing aids are covered up to age 18 and are supplied every 5 years, except as required by law. **Allergy Services** $10 copayment per visit for allergy injections including the allergy serum. Allergy testing is subject to the medical office visit copayment. **Home Injectables** $75 copayment of injectables for home use **Cardiac Rehabilitation** $40 copayment per visit for cardiac rehabilitation. Limited to 10 visits per benefit year.

PART C: LIMITATIONS AND EXCLUSIONS

	IN-NETWORK THROUGH UA NET PROVIDERS ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[10]	Not applicable; Plan does not impose limitation periods for pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable; Plan does not exclude coverage for pre-existing conditions.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by plan. List of exclusions is available immediately upon request from your third party administrator. Review them to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK THROUGH UA NET PROVIDERS ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	Yes
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who scheduled the procedure or hospital care is responsible for obtaining the preauthorization.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
39. What is the main customer service number?	800-735-6072
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	HMO Colorado, Complaints and Appeals 700 Broadway Denver, CO 80273 800-735-6072
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form #'s 07-00027 Group – Large
43. Does the plan have a binding arbitration clause?	No

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

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

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

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

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

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

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

[4a] Coverage shall be provided for asymptomatic, average risk adults who are 50 years of age or older and covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of

cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.

[4b] Benefits provided for the following tests as determined by the provider to detect adenomatous polyps or colorectal cancer: modalities that are currently included in an "A" recommendation or a "B" recommendation of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services.

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

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

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

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

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

[10] Waiver of pre-existing condition exclusions. State law requires plans to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your third party administrator for details.

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

[12] Hearing aids for dependent children under the age of 18 are covered. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review.

Welcome

Welcome to HMO Colorado, where it's Our mission to improve the health of the people We serve. You have enrolled in a quality self-funded health benefit plan ("Plan") that, pursuant to the terms of this Benefits Booklet, pays for many of your health care expenses, including most expenses for Physician and outpatient care, Emergency care and Hospital inpatient care. **Important: This is not an insured benefit Plan.** *The benefits described in this Benefits Booklet or any rider or amendments hereto are funded by the employers and subscribers. The benefits are paid from the Trust. Anthem provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.*

Throughout this Benefits Booklet "Our", "We" and "Us" refer to HMO Colorado or UA Net.

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

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

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

John Martie
President and General Manager
HMO Colorado

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

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

Health benefit coverage is defined in the following documents:

- This Benefits Booklet, the *Health Benefit Plan Description Form* and any amendments or endorsements thereto
- The employer required Benefits Enrollment/Change Form available from your employer and any other application required by the employer for the Subscriber and the Subscriber's Dependents
- The Health Benefit ID Card

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

- The Employer Master Application
- The University of Colorado Health and Welfare Trust ("Trust")
- The Administrative Services Agreement among Us, the Trust Committee, on behalf of the Trust, and the 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 Benefits Booklet. If any question arises about the interpretation of any provision of this Benefits 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 Benefits Booklet.

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

Important: This is not an insured benefit plan. The benefits described in this Benefits Booklet or any rider or amendments hereto are funded by the employers and subscribers. The benefits are paid from the Trust. HMO Colorado provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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Your Rights and Responsibilities

We are committed to:

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

You have the right to:

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

You have the responsibility to:

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

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

About Your Health Benefits

This is a Health Maintenance Organization (HMO) health benefit Plan. We have coordinated and contracted through the UA Network Managed Care Network with a network of Physicians, Hospitals, Pharmacies and support services (e.g., laboratory, x-ray, pharmacy, and physical therapy) to arrange for or provide comprehensive health care services to Members for a fixed payment. Learning how an HMO works can help you make the best use of your health care benefits. Provider lists are furnished, without charge, as a separate document, by going to www.anthem.com/universityofcolorado. The *Health Benefit Plan Description Form* lists Copayments and certain benefit limits you may incur.

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

Primary Care Physicians

A key feature of this Plan is that one doctor will be primarily responsible for delivering and coordinating all of your care. That Physician is called a Primary Care Physician (PCP). PCPs are typically internal medicine Physicians, family practice Physicians, general practitioners or pediatricians. As your first point of contact, the PCP provides a wide range of health care services, including initial diagnosis and treatment, health supervision, management of chronic conditions, and preventive care and Referrals to Specialists, when appropriate. Your PCP can provide you referrals and information about Specialists who are In-Network.

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

Members do not need a referral from their PCP to access the services of an OB/GYN Provider or for medical eye care; you may self-refer to In-Network OB/GYN Provider for obstetrical and gynecological services or to an ophthalmologists for medical eye care. These self-referral services will only be covered when services are received from an OB/GYN Provider or ophthalmologists in the UA Network.

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

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

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

Selecting A PCP

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

To locate a PCP, you may call the customer service number that is listed on your identification card. You may also search for PCP's and hospital on-line at www.anthem.com/universityofcolorado. Our website is continuously updated and is the most up-to-date list of Our PCPs. Some Providers are listed as accepting existing patients only. However, We may not have notice of new limitations of this kind. Therefore, even if the listing for the PCP you

select does not indicate patient limitations, you should call the PCP to confirm that the Provider is still accepting new patients (unless you are already an existing patient of the PCP).

Visiting A PCP

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

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

After hours care is provided by your physician who may have a variety of ways of addressing your needs. You should call your PCP for instructions on how to receive medical care after the PCP's normal business hours, on weekends and holidays, or to receive non-Emergency Care and non-Urgent Care within the service area for a condition that is not life threatening but that requires prompt medical attention. In case of an Emergency, you should call 911 or go directly to the nearest Emergency room.

Changing PCPs

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

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

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

If you change primary residence or place of employment to a location that is not convenient to your current PCP's office, you may choose a new PCP nearer to you new residence or place of employment, within Our Service Area.

Referrals

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

You do not need a referral from the PCP for:

- An Emergency or Urgent situations
- Care from an in-network OB/GYN physician or certified nurse midwife for obstetric or gynecologic care
- Care from an in-network ophthalmologists for medical eye care
- Mental health services

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

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

Care Outside of Colorado

When you are outside Our Colorado service area benefits are only available for Emergency or Urgent care, except as specified in the "Care Outside of Colorado" section of the **COVERED SERVICES** section of this Benefits Booklet.

Cost Sharing Requirements

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

We work with Physicians, Hospitals, pharmacies and other health care Providers to control health care costs. As part of this effort, most Providers who contract with Us agree to control costs by giving Us discounts. The discounts range from paying a fixed amount per day for a Hospital admission to paying a Provider a fixed amount per month for each Member who has selected that Provider as the Member's PCP. These discounts do not affect the Copayments that are listed on the *Health Benefit Plan Description Form*. However, you benefit from Provider discounts.

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

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

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

Copayment

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

Services from Out-of-Network Providers are covered only under limited circumstances. Non-Emergency services from Out-of-Network Providers are **not covered** unless specifically authorized by Us **before** services are received. If We, in administering the plan for the employer, have preauthorized the Member to seek Covered Services from an Out-of-Network Provider, We will apply the In-Network level of benefits and the Member will not be required to pay more for the services than if the services have been received from an UA Net In-Network Provider. However, when preauthorized, or for Emergency care and Urgent care, Copayments for Covered Services received from an Out-of-Network Provider are the same for Covered Services received from an In-Network Provider.

Benefit Period Maximum

Some Covered Services have a maximum number of days, visits or dollar amounts that We will allow during a Benefit Period. See the *Health Benefit Plan Description Form* for those services which have a Benefit Period Maximum.

Lifetime Maximum

Only certain services are subject to a Lifetime Maximum. We will not pay for Covered Services once you have met the Lifetime Maximum payment allowance for those services. Those services with a Lifetime Maximum benefit limit may be found in the *Health Benefit Plan Description Form*. The Lifetime Maximum payment allowance applies to any payments that We make for Covered Services under this Benefits Booklet, or any other product within the same benefit design. As a result, if you change between two or more of Our products within the same benefit design, the same Lifetime Maximum payment allowance applies. If however, you change from coverage under one benefit design to coverage under a different benefit design, a separate and new Lifetime Maximum payment allowance begins with the new coverage.

Managed Care Features

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

We may subcontract particular administrative processes to organizations or entities that have specialized expertise in certain areas such as Disease Management. Due to the unique arrangement of this UA Net Plan we have subcontracted with UA Net for Preauthorization of certain services. The In-Network Provider who schedules an admission or orders the procedures or service is responsible for obtaining Preauthorization and for knowing who to contact for Preauthorization. To determine which services require Preauthorization and/or to be sure that Preauthorization has been obtained, you may contact customer service. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims payment or customer service duties on Our behalf.

Transition of Care

A new Member to this coverage may be receiving ongoing care for a medical condition. Examples of ongoing care include prenatal/obstetrical care, Home Care or Hospice Care. We strive to avoid disruption of a new Member's care through Our transition of care policy. To facilitate the transition of care, you or your provider must review the reference sheet, complete a Transition of Care Form and submit them to Us for review. You or your Provider may request a reference sheet and Transition of Care Form by calling the Customer Service number on your ID card.

Our Process to Determine If Services are Covered

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

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

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

Experimental/Investigational and/or Cosmetic Procedures - In administering benefits on behalf of the employer, We will not pay for any services, procedures, surgeries or supplies that We consider Experimental/Investigational and/or cosmetic. Additionally We will not pay for complications arising from any services, procedures, surgeries or supplies that we consider Experimental/Investigational and/or cosmetic.

Appropriate Place and Preauthorization

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

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

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

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

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

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

- **Scheduled Admissions -** Your Provider must obtain Preauthorization from UPI before the admission for all scheduled inpatient admissions as well as concurrent reviews for continued stays that exceed the number of days preauthorized. Preauthorization must be requested from UPI at least seven days before your admission. UPI will send written confirmation of the decision to you and your Provider within two business days of receipt of all necessary information.
- **Unscheduled (Emergency) Admissions -** We require notification of an Emergency admission within one business day after the admission. You are responsible for ensuring that We have been notified of the unscheduled admission unless you are unable to do so. Examples of Emergency admissions include admissions involving accidents or the onset of labor in pregnancy. Failure to notify Us may result in a reduction or denial of benefits.

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

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

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

Upon receipt of a Preauthorization request, We may require additional information to determine the Medical Necessity of the procedure. We will send written confirmation of Our decision to you and your Provider within two

business days of Our receipt of all necessary information. The Preauthorization will be valid only for a specific place and period of time. You must obtain the requested service within the time allotted in the Preauthorization and at the place authorized. If the Preauthorization period expires, or if additional services are requested, the Provider must contact Us to request another Authorization.

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

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

Appropriate Length of Stay

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

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

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

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

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

Ongoing Care Needs

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

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

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

Depending on the level of Care Management you may need, a Care Manager may be assigned to you. We employ nurses and other medical staff with special training in the coordination of care in complex cases. You may or may

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

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

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

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

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

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

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

Membership

Subscriber

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

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

Dependents

A Subscriber's Dependents may include the following:

- **Legal Spouse**.
- **Common-law Spouse**. The Subscriber must submit a Common-Law Marriage Affidavit for the common-law Spouse to be considered for enrollment. The Common-Law Marriage Affidavit may be obtained through the employer. All references to spouse in this Benefits Booklet include a Common-Law spouse.
- **Same Gender Domestic Partner (SGDP).** The Subscriber must submit a Same-Gender Domestic Partner Affidavit for the domestic partner to be considered for enrollment. The SGDP Affidavit may be obtained through the employer. There may be tax consequences to the Subscriber when enrolling his or her SGDP and his or her SGDP's child. All references to spouse in this Benefits Booklet include a SGDP except a SGDP is not eligible for COBRA coverage. However a SGDP and children of a SGDP are eligible through the employer for continuation of coverage under the same time conditions and time periods as COBRA.
- **Newborn Child**. A newborn child born to the Subscriber or Subscriber's Spouse is covered under the Subscriber's Membership for the first 31 days after birth. If the mother of the newborn child is a Dependent child of the Subscriber, the newborn is **not** provided benefits (see the **Grandchild** heading in this section).

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

  To continue the newborn child's participation in the coverage beyond the 31-day period after the newborn child's birth, the Subscriber must complete and submit a Benefits Enrollment/Change Form available from the employer to add the newborn child as a Dependent child to the Subscriber's policy. The employer must receive the Benefits Enrollment/Change Form within 31 days after the birth of the child to continue coverage for the 32nd day and thereafter. For example: the newborn child is born on January 15th, you have 31 days from the birth to notify the employer of the newborns birth. If the current coverage is a single only policy and the child is to continue coverage beyond 31 days, the effective of coverage for the newborn child is on the date of birth and the change in the premium payment is effective on February 1st.
- **Adopted Child**. An unmarried child (who has not reached 18 years of age) adopted while the Subscriber or the Subscriber's Spouse is eligible for benefits will be covered for 31 days after the date of placement for adoption.

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

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

- **Dependent Child**. A Subscriber's son, daughter, stepson, stepdaughter or eligible foster child, including a legally adopted individual or an individual who is lawfully placed with the Subscriber for legal adoption , or a child for whom the Subscriber has established parental responsibility (as evidenced by court documents), or a son or daughter of a Subscriber's SGDP, including a legally adopted individual or an individual who is lawfully placed with the Subscriber's SGDP for legal adoption, or a child for whom the Subscriber's SGDP has established parental responsibility (as evidenced by court documents), may be covered under the terms of this Benefits Booklet through the end of the calendar month in which the child turns 27. There may be tax consequences to the Subscriber when enrolling his or her child through the calendar month in which the child turns age 27.There may also be tax consequences to the Subscriber when enrolling his or her SGDP's child. A Dependent child of a Subscriber who is no longer eligible for coverage may be eligible for continuation coverage. Information can be found under the heading **Continuation of Benefits** in this section.
- **Disabled Dependent Child**. An unmarried child who is 19 years of age or older, medically certified as disabled, and Dependent on the parent may be covered under the terms of this Benefits Booklet. The employer must receive notice of the disability for the disabled Dependent benefits to continue after the Dependent child turns age 19.
- **Grandchild.** A grandchild of a Subscriber or a Subscriber's Spouse is not eligible for benefits unless the Subscriber or the Subscriber's Spouse is the grandchild's court-appointed permanent guardian or has adopted the grandchild. The Subscriber must submit an employer required Benefits Enrollment/Change Form to the employer and evidence of court appointment as permanent guardian or documents evidencing a legal adoption. Another option is to enroll the grandchild under a separate individual insurance policy with Anthem Blue Cross and Blue Shield, subject to its terms and conditions.

Medicare-Eligible Members

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

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

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

Enrollment Process

For eligible Subscribers and their eligible Dependents to participate in the Plan, the Subscriber must follow the employer's enrollment process, which details who is eligible and what forms are required for enrollment. Eligibility for benefits under this Benefits Booklet begins as of the Effective Date as indicated in the employer's files. No services received before that date are covered.

You need to contact your Group Benefit Office or Human Resource department for details regarding required documentation for adding common-law spouse or Same Gender Domestic Partner (SGDP).

- University of Colorado – Payroll & Benefit Services
- University Physicians, Inc. – Human Resources
- University of Colorado Hospital – Human Resources

Note: Submission of an employer required Enrollment Change/Form to the employer does not guarantee your enrollment.

Initial Enrollment

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

established waiting period as determined by the employer. The employer will inform the employee of the length of the waiting period.

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

Open Enrollment

Any eligible employee who has satisfied the waiting period as defined by the employer may enroll during the employer's annual Open Enrollment period, which is generally a 31-day period before the employer's Anniversary Date. The employer's benefit coordinator will provide the Open Enrollment period date and the Anniversary Date to the eligible employee.

Newly Eligible Dependent Enrollment

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

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

Special Enrollment for Eligible Employees and Eligible Dependents

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

Family Status Change - Qualifying events for special enrollment due to a family status change include marriage, divorce, birth, placement for adoption or the issuance of a qualified medical child support order. Benefits under this Plan with Us will be effective on either the date of the qualifying event or the first of the month following the qualifying event, dependent on the qualifying event. When the qualifying event is a birth, and the mother is not previously enrolled, any charges related to labor and delivery due to the birth are not covered. The employer must receive the completed Benefits Enrollment/Change Form within 31 days after the date of the qualifying event. Proof of the qualifying event may be required by the employer

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

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

Status Change of State Medicaid Plan or State Child Health Insurance Program (SCHIP) – Loss of eligibility from a state Medicaid or SCHIP health plan is also a qualifying event for special enrollment for the eligible

employee and/or eligible dependents. The employee must properly file an application with the employer within 60 days after coverage has ended, Medicaid coverage has ended, or 60 days after SCHIP coverage has ended. In addition, special enrollment is allowed for the employee who becomes eligible for premium assistance, with respect to coverage under the employer's health coverage, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. Similarly, the employee must properly file an application with the employer within 60 days after the eligibility date for assistance is determined.

Military Service

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

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

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

How to Change Coverage

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

Termination

Active Policy Termination

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

- On the date the Plan described in this Benefits Booklet is terminated.
- Upon the Subscriber's death.
- When the required subscription or administrative fee has not been paid.
- 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 Benefits Booklet.
- Coverage under this Benefits Booklet ends when you are deemed a "working aged," as defined by federal law and you choose Medicare as your primary coverage. Medicare becomes your primary coverage.
- 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 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.
- When you move and therefore neither reside nor work within the service area unless you are continuing coverage under COBRA continuation, you must notify Us within 31 days of such a change in location. Coverage will end on the last day of the month in which the change of residence is reported; until that time, the only out-of-area services covered will be Emergency care and Urgent care. Non-Emergency care will not be covered.
- If you do not notify Us of a change of residence or workplace to an area outside Our Service Area, and We later become aware of the change, your benefits may be retroactively terminated to the date of the change of residence or place of employment. You will be liable to Us and/or the Providers for payment for any services covered in error.
- When We cease operations.

Dependent Coverage Termination

To remove a Dependent from the Plan, the Subscriber must complete an employer required Benefit Enrollment Change Form. The Effective Date of the change will be the end of the month in which the change was received. We reserve the right to recoup any benefit payments made after the termination date.

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

- When the Subscriber's employer notifies Us to cancel benefits for a Dependent.
- When the Dependent child no longer qualifies as a Dependent by definition. Such a Dependent has the right to elect COBRA coverage.
- Final divorce decree or legal separation for a Dependent Spouse. Such a Dependent has the right to elect COBRA coverage.
- When legal custody of a child placed for adoption is terminated.
- Death of the Dependent.

Certificate of Creditable Coverage

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

What We Will Pay for After Termination

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

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

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

Continuation of Benefits

Family and Medical Leave Act

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

COBRA Eligibility and Notification

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

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

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

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

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

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

- The surviving Spouse and surviving children of a covered employee, when the covered employee dies.
- The covered employee, if the employee became eligible for Medicare benefits before COBRA election.
- Spouse and Dependent children of a covered employee, if the employee has a termination or reduction in hours that occurs less than 18 months after the employee became entitled to Medicare benefits.
- Spouses and Dependent children of a covered employee, when the employee and the Spouse separate or divorce.
- Dependent children of the covered employee, when the Dependent children lose eligibility as Dependents.
- COBRA coverage is available to children born or placed for adoption during the period of COBRA coverage for the remainder of either the 18-month or 36-month COBRA continuation period. The qualifying event that triggered the COBRA coverage will determine the length of the continuation period for the newborn or adoptee.

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

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

Termination of COBRA

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

Continuation coverage may terminate before the continuation period expires if:

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

Covered Services

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

A PCP provides you with basic health services and other medical services. Sometimes the PCP determines that it is necessary, or you request, to see a Specialist or other Provider. Your PCP must recommend and coordinate any care provided by other health care providers. This is accomplished through a referral. A referral is the formal recommendation, made by the PCP or other physician, that you receive care from a Specialist or a different Provider. The PCP will submit a referral for Our records. **Services received without a referral are not covered and you will be liable for all costs incurred when not obtained without a referral.** Referral guidelines can be found under the heading REFERRALS in the **ABOUT YOUR HEALTH COVERAGE** section. A referral is not complete until we have approved the referral. You and requesting Provider will receive notification of approval of a referral. You may also contact the PCP or customer service to receive verification that a referral has been approved.

If you use a Non-Network Provider, your claim will be denied unless services were for Emergency or Urgent care, or preauthorized by Us.

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

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

Preventive Care Services

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

Preventive Care Services means care that is rendered to prevent future health problems for a Member who does not exhibit any current symptoms. Preventive Care Services include:

Routine Exams and Immunizations

- Routine or periodic exams, e.g., pelvic exams. Exams are covered according to the frequency determined by your Provider. Having the right exams at the right times may help you avoid serious illness. Check with your Provider for specific health guidelines based on your age, sex and family history;
- Family history, current health problems and lifestyle all affect your risk for disease. Talk to your Provider to determine if you are at high risk for specific diseases and then together determine your appropriate exam schedule;
- Immunizations (including those required for school) and immunizations against cervical cancer to the extent benefits are required by applicable insurance law. Immunizations protect you from certain diseases and help prevent epidemics. While immunization risks to your health are low, the risks from disease are high. Both children and adults need immunizations to help keep them healthy. Check with your Provider about the immunization schedules recommended for children and adults;
- Child Health Supervision Services (including limited smoking cessation services) for Dependent children up to age 13, but only to the extent benefits are required by applicable insurance law.
- Annual medical diabetes eye exams, or in accordance with the frequency determined by your Provider.
- Flu shots when received from your Providers office. If it's more convenient to get your flu shot at a flu shot clinic or from an Out-of Network provider, you may be eligible for reimbursement of some or all of your out of pocket costs. Examples of locations that may provide flu shots and may be considered flu shot

clinics include your local pharmacy, your place of employment, a grocery store, Wal-Mart, Walgreens or Costco. There may be additional flu shot clinic locations available to you For the reimbursement amount allowed visit our website at www.anthem.com/universityofcolorado or call our customer service department. This annual reimbursement is subject to change. A flu shot received from an Out-of-Network Provider or Facility, or that is otherwise paid in full or part by another party is not covered.
- Pneumococcal vaccinations

Routine/Preventive Diagnostic Services

- One routine screening mammogram is covered per Benefit Period regardless of age, or in accordance with the frequency determined by your provider;
- Routine cytologic screening (pap test);
- 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;
- Colon 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 subject to the provisions of the Outpatient Services section and is not part of the Preventive Care Services section;
- Routine PKU tests for newborns;
- Cholesterol screening for lipid disorders;
- Tobacco use screening of adults and tobacco cessation interventions by your Provider;
- Alcohol misuse screening and behavioral counseling interventions for adults by your Provider.
- Coverage for benefits in this section shall meet or exceed those required by applicable insurance law, which may change from time to time.

Infertility Services

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

Benefits include Inpatient Services, Outpatient Services, and Physician Office Services for the diagnosis of infertility. Covered Services include only diagnostic and exploratory procedures to determine the cause of infertility. See the *Health Benefit Plan Description Form* for benefit limitations and the lifetime maximum amount.

Maternity Services and Newborn Care

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

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

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

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

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

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

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

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

We pay for Covered Services from a Provider for therapeutic termination of pregnancy.

Diabetes Management Services

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

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

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

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

Diabetic supplies are covered under the **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES** section and the **RETAIL PHARMACY/MAIL ORDER PRESCRIPTION DRUGS** section.

Physician Office Services

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

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

Covered Physician office services include visits for medical care, consultations and second opinions to: examine, diagnose and treat an illness or injury performed in the Physician's office, including birth control. Office visits also include allergy injections and allergy serum, and allergy testing. Office visits may include administration of injections. If the office visit is with a physician other than the PCP, a referral must have been approved prior to the visit.

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

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

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

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

Inpatient Services

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

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

Inpatient Services include:

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

Skilled Nursing Care Facility (SNF)

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

Non-Acute Inpatient Therapy

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

Room, Board and General Nursing Services

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

Ancillary Services

- Operating, delivery and treatment rooms and equipment;
- Prescribed drugs administered as part of the Inpatient admission;
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services;
- Therapy Services; and
- Charges for processing, transportation, handling and administration of blood. Charges for blood, blood plasma and blood products unless received from a community source.

Professional Services

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

Copayment Waiver

When a Member is transferred from one Hospital or other Facility Provider to another Hospital or other Facility Provider on the same day, any Copayment stated per admission in the *Health Benefit Plan Description Form* is waived for the second admission.

Outpatient Services

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

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

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

Outpatient Services may include administration of injections.

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

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

Diagnostic Services

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

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

- X-ray and other radiology services;
- Laboratory and pathology services;
- Cardiographic, encephalographic and radioisotope tests;
- Ultrasound services;
- Allergy tests; and
- Hearing tests, unless related to an examination for prescribing or fitting of a hearing aid.
- Genetic testing when allowed by HMO Colorado and UA Net's medical policy.
- Ultrafast CT scans when Preauthorized and allowed by Anthem's medical policy.

Surgical Services

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

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

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Sterilization services;
- Anesthesia and surgical assistance;
- Usual and related pre-operative and post-operative care; and
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care.

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

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

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

Care Outside of Colorado

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

Away From Home Care (Guest Membership Program)

Available ONLY for covered children who reside outside Colorado and who are enrolled in UA Net.

NOT AVAILABLE FOR EMPLOYEES OR SPOUSE(S)/SAME GENDER DOMESTIC PARTNERS

WHAT IS THE AWAY FROM HOME CARE PROGRAM?

The Away From Home Care Program provides Guest Membership if your covered child will be outside of the UA Net service area for at least 90 days in one location.

Guest Membership allows your covered child to join another Blue Cross Blue Shield Plan and receive the full range of benefits offered by that Plan, excluding any "riders" you may have, i.e. prescription drugs, chiropractic care, or dental care. Review the Anthem provider directory at www.anthem.com\UniversityofColorado to find pharmacy locations and how to enroll in the University of Colorado Hospital mail order prescription service. **Prescription drug coverage will be provided exactly as it works for any UA Net member.**

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

WHERE IS GUEST MEMBERSHIP AVAILABLE?

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

The name of the City, County and State away from home will help us locate a Host Plan. Reasons for Guest Membership may include students away at school, the child (ren) of families living apart, and child's long-term travel. Students away at school and child (ren) of families living apart can have up to one year for Guest Membership. Guest Membership for a child's long term travel is limited to 180 days (6 months). **Renewals must be requested by you before the end of your child's Guest Membership.**

POINTS TO REMEMBER:

- It usually takes 30 days from the date of the request to establish a Guest Membership in a Host Plan. Membership becomes effective **15 days after receipt of the signed application.**
- Please call 800-827-6422 to request an application. You will need to know the "away from home" address including zip code. If a Guest Member is a minor, you will need to supply the name of the person caring for them in the Host Plan.
- The application will be sent to you, the subscriber, for signature and completion of the application.
- The Host Plan will contact the Guest Member to select a PCP and issue an ID card and enter the membership in their system.
- Guest Membership always includes an expiration date.
- Eligible Guest Memberships must be renewed each year. **Student certification through the home plan does not automatically renew a Guest Membership.**
- **Renewal letters will be sent 45 days prior to the expiration date.**

- **Urgent Care** is available while your child is waiting for Guest Membership to become effective. Call your Home Plan Customer Service at the number on the back of your ID card or call the Provider Locator at 800-810-2583.

The enrolled child MUST use their GUEST ID card when away from home and their UA NET card when in Colorado.

PARTICIPATING STATES: (SUBJECT TO CHANGE)

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

Emergency Care and Urgent Care

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

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

Emergency Care

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

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

For Inpatient admissions following Emergency Care, you should contact Us within 48 hours of admission or as soon as reasonably possible to obtain authorization for a specific length of stay. When We are contacted for Authorization, you will be notified of the number of days considered Medically Necessary for your diagnosis.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from 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.

Urgent Care

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

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

Obtaining Emergency or Urgent Care

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

- Know the difference between an Emergency and an Urgent Care situation;
- If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. If you are experiencing an Urgent Care medical problem, go to an Urgent Care Center or your Physician's office. If there is not one nearby, then go to the Hospital;
- Call your PCP or Us within 48 hours or as soon as reasonably possible;
- Ask if the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan. More than likely it does;
- If the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, show your Health Benefit ID Card to the Hospital staff or Physician. If it does not contract with the local Blue Cross and Blue Shield Plan, you will need to pay the bill and file a claim form with Us;
- If the Hospital or Urgent Care Center contracts with the local Blue Cross and Blue Shield Plan, the Hospital or Urgent Care Center will verify your eligibility and get your benefit information from a nationwide electronic data system;
- After you are treated, your claim is sent to Us. For covered services, You only have to pay any Copayments as stated in your *Health Benefit Plan Description Form*; and

- You may receive an Explanation of Benefits form if your Provider did not bill us.

Emergency and Urgent Care outside the country:

- Go to the nearest health care facility;
- Call your PCP or Us within 48 hours or as soon as reasonably possible;
- Once your care is completed, you will need to pay the bill. (You may want to use a credit card. The credit card company will automatically transfer the foreign currency into American dollars for you.) Keep all your receipts;
- When you return home, call Us at the number on the back of your Health Benefit ID Card or visit the www.anthem.com/universityofcolorado for a medical claim form;
- Fill out the claim form and submit it with your receipts to Our address on the form. (The amount submitted must be in American dollars); and
- You will be reimbursed based on the benefits of your Benefits Booklet.

Ambulance and Transportation Services

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

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

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

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

Ambulance services are a Covered Service only when Medically Necessary and:

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

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

Therapy Services

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

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

From the Member's birth until the Member's sixth (6th) 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 it to maintain or improve functional capacity. The level of benefits between the third (3rd) birthday and the sixth (6th) birthday shall exceed the limit of twenty (20) visits for each therapy if such therapy is indicated in a Member's Treatment Plan for Autism Spectrum Disorders and is determined by Us to be Medically Necessary. From the Members birth until the Member's third (3rd) birthday, these services shall be provided only where required by applicable law and only to the extent required by applicable law.

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

- **Physical Therapy** including treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain,

restore function and to prevent disability following illness, injury or loss of a body part, or as a result of a Congenital Defect or Birth Abnormality.

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

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. Benefits are allowed up to a maximum of 10 visits per Members Benefit Period.
- **Chemotherapy** for the treatment of disease by chemical or biological antineoplastic agents. Chemotherapy services are available through the Providers office. Benefits are subject to the specialist's copayment.
- **Dialysis** treatments of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. Benefits are subject to the specialist's copayment.
- **Radiation Therapy** for the treatment of disease by x-ray, radium or radioactive isotopes.
- **Inhalation Therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation.

Autism Services

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

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

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

Treatment for Autism Spectrum Disorders must be prescribed or ordered by a licensed physician or licensed psychologist, and services must be provided by an Autism Services Provider. Coverage of Autism Spectrum Disorders in this section may be in addition to coverage provided for early intervention and congenital defects and birth abnormalities. Autism services and the autism Treatment Plan are subject to Utilization Review.

Chiropractic Services

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

To obtain Chiropractic Services, you must contact Our chiropractic Subcontractor before you receive services. If you do not contact Our chiropractic Subcontractor, services are not covered. If you receive services from a Provider other than a Provider designated by Our chiropractic Subcontractor, services will be considered Out-of-Network and

are not covered. You may self-refer for the initial evaluation (1 visit), after that Preauthorization is required for subsequent visits. To obtain Preauthorization, your In-network chiropractic Provider must call Our chiropractic Subcontractor for determination of Medical Necessity and appropriate treatment. Your treatment may be reviewed at periodic intervals to determine if services continue to be Medically Necessary.

Coverage for Chiropractic Services when provided as part of office services includes limited office visits with manual manipulation of the spine, x-ray of the spine and physical therapy modalities and procedures. If you visit a chiropractor more than once in a single day, each such visit will be counted as one visit. Services must be for the treatment of a neuromusculoskeletal condition and must begin within six months from the date on which the condition first occurred. Refer to the **DIAGNOSTIC SERVICES** section for radiology services received outside of the chiropractor's office.

Refer to your *Health Benefit Plan Description Form* for benefit limitations.

Physical Medicine and Rehabilitation Services

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

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

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

Home Care/Home IV Therapy Services

Benefits in this section are subject to the **GENERAL EXCLUSIONS** section of this Benefits 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 *Health Benefit Plan Description Form* when provided by a Home Care Agency);
- Medical and Surgical Supplies;
- Durable Medical Equipment; and
- Prescription Drugs (only if provided and billed by a Home Health Care Agency).

Home IV Therapy

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

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

Medical Foods

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

Benefits are provided for medical foods for home use for metabolic disorders, which may be taken orally or enterally. A Provider must have prescribed the medical foods that are designed and manufactured for inherited

enzymatic disorders involved in the metabolism of amino, organic, and fatty acids. Such disorders include phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia and propionic acidemia. The maximum age to receive benefits for phenylketonuria is 21 years of age; except the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is 35 years of age. This benefit does not include enteral nutrition therapy or medical foods for Members with cystic fibrosis or lactose- or soy- intolerance.

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

Hospice Care Services

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

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

Hospice Services include:

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

Human Organ and Tissue Transplant Services

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

For cornea and kidney transplants, the transplant or tissue benefits or requirements described below do not apply. Those services are paid as Inpatient Services, Outpatient Services, or Physician Office Services depending on where the service is performed. Coverage for Human Organ and Tissue Transplants are covered when provided as part of Physician Office Services, Inpatient Services, and Outpatient Services.

This Plan shall provide benefits for Human Organ and Tissue Transplant services only when We have Preauthorized the services. We must designate and approve the Hospital who is performing the specific Covered Services provided under this benefit. Please note, not every designated Hospital performs each of the specified Covered Services.

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

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

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

- Kidney-Pancreas;
- Pancreas;
- Liver;
- Peripheral Stem Cell (i.e. bone marrow); and
- Small bowel.

The above covered transplant services list may be amended to include additional organ or tissue transplants based on our medical policy.

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

Other services

- Immunosuppressant drugs prescribed for Outpatient use in connection with a covered Human Organ and Tissue Transplant that are dispensed only by written prescription and that are approved for general use by the Food and Drug Administration, but only if your coverage has a Prescription Drug benefit.
- We will provide assistance with reasonable and necessary travel expenses as determined by Us, when you receive prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the covered facility and lodging for the covered Member and one companion. If the Member receiving the treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. You must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. You may contact Us for detailed information. No benefits will be paid until after the transplant services are received. For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code. Benefits for transportation and lodging are limited to a maximum benefit as listed on the *Health Benefit Plan Description Form*.
- Benefits for transportation and lodging for the transplant recipient and companion(s) is limited to a maximum payment of $10,000 per transplant, not to exceed a specific total per day for reasonable and necessary lodging and meal expenses.
- Transportation of the donor organ or tissue.
- Evaluation and surgical removal of the donor organ or tissue and related supplies.

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

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

Covered Services related to the donor and/or donated organ or tissue, such as Hospital, surgical, medical, storage and transportation costs are subject to a maximum payment of $25,000. Benefits provided to the donor will be charged against the recipient Member's coverage and will apply toward the Member's Lifetime Maximum for Human Organ and Tissue Transplants.

No benefits will be provided for procurement of a donor organ or organ tissue that is not used in a covered Transplant procedure, unless the transplant is cancelled due to the Member's medical condition or death and the organ cannot be transplanted to another person.

The benefits for all Covered Services specified in this section for Human Organs and Tissue Transplants are limited to a Lifetime Maximum payment of $1,000,000 per covered Human Organ and Tissue Transplant. This includes all Covered Service maximums specified in this section. If you receive a covered Human Organ and Tissue Transplant e.g., heart transplant, and later require another transplant of the same type e.g. (another heart transplant), the covered benefits for the new transplant are limited to the remaining (if any) Lifetime Maximum benefits available for the transplant under this Benefits Booklet or any successive Benefits Booklet with Us.

Only those Human Organ and Tissue Transplants and directly related procedures specified in this section are Covered Services under this benefit. Benefits will only be provided for Covered Services and supplies furnished to the transplant recipient during the period beginning five (5) days before the covered Human Organ and Tissue Transplant procedure and ending three hundred sixty-five (365) days after the covered transplant procedure is performed.

Medical Supplies, Durable Medical Equipment, and Appliances

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

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

Durable Medical Equipment/ Oxygen

Benefits are provided for medial supplies such as:

- Syringes, needles, oxygen, surgical dressings, splints and other similar items that serve only a medical purpose, including diabetic supplies; or
- The rental (or, at Our option, the purchase) of Durable Medical Equipment prescribed by a Physician or other Provider. Rental costs must not be more than the purchase price. This equipment must serve only a medical purpose and be able to withstand repeated use. Repair of medical equipment is covered; or
- Oxygen and the rental of the equipment needed to administer oxygen (one stationary and one portable unit per Member); or
- The first wig following cancer treatment; or
- Either one set of standard prescription eyeglasses or one set of contact lenses (whichever is appropriate for the medical condition) when necessary to replace human lenses absent at birth or lost through intraocular Surgery, ocular injury or for the treatment of keratoconus or aphakia; or
- Breast prostheses and surgical brassieres following a mastectomy (see the *Health Benefit Plan Description Form* for benefit limitations for surgical bras).

See the *Health Benefit Plan Description Form* for benefit maximums for durable medical equipment and oxygen. Colostomy and ostomy supplies are subject to a separate Benefit Period Maximum.

Prosthetic Appliances

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

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

For prosthetic arms and legs the allowance is as provided for under federal laws for health insurance for the aged and disabled. Prosthetic arms and legs are not subject to the Benefit Period Maximum.

Orthopedic Appliances

Purchase, fitting, needed adjustment, repairs, and replacements of orthopedic braces and supplies that are rigid or semi-rigid supportive device and that limit or stop motion of a weak or diseased body part and podiatric shoe inserts. See the *Health Benefit Plan Description Form* for benefit maximums.

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

Hearing Aid Services

The following hearing aid services are covered up to your eighteenth (18th) birthday when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist. Hearing aid benefits are not subject to the annual maximum limit for medical supplies, durable medical equipment and appliances Benefit Period Maximum:

- Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be provided as part of the **DIAGNOSTIC SERVICES** section.

- Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment. Initial and replacement hearing aids will be supplied every 5 years, or when alterations to the existing hearing aid cannot adequately meet the child's needs.
- Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

Dental Related Services

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

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

Dental Anesthesia

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

Cleft Palate and Cleft Lip Conditions

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

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

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

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

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

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

Biologically Based Mental Illness conditions, autism, other mental disorders of posttraumatic stress disorder, drug and alcohol disorders, dysthymia, cyclothymia, social phobia, agoraphobia with panic disorder, general anxiety disorder, anorexia nervosa and bulimia nervosa (to the extent anorexia nervosa and bulimia nervosa are treated on an Out-Patient, day treatment and In-Patient basis, excluding residential treatment) are covered under your medical benefits and are not subject to the limitations of the Mental Health Care benefits.

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

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

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

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

Partial Hospitalization Services. The same services covered for Inpatient Services for Mental Health Services, Alcohol and Substance Dependency are also covered for partial hospitalization. Partial hospitalization may be substituted for Inpatient benefits at two (2) days for each available Inpatient day. Partial hospitalization means continuous treatment for at least three (3) hours but no more than twelve (12) hours in any twenty-four-(24) hour period Partial Hospitalization treatment is covered only when the Member receives medically necessary care through a day treatment program as determined by the facility.

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

Retail Pharmacy/Mail Order Prescription Drugs

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

This section describes Our outpatient pharmacy benefits for medications obtained through a Retail or mail-order Pharmacy.

The Outpatient retail pharmacy benefits available under this Benefits Booklet are managed by the Pharmacy Benefits Manager (PBM). The PBM is the entity with which HMO Colorado has contracted to administer its prescription drug benefits. The PBM offers a nationwide network of retail pharmacies, and clinical services.

Mail Order prescriptions are managed by The University of Colorado Hospital Mail Order Prescription Service.

Outpatient Pharmacy services do not include services received in the Hospital as an Inpatient, if a Medical Supply, durable medical equipment or appliance. Refer to the **INPATIENT SERVICES,** and **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT AND APPLIANCES** sections for services covered by the Benefits

Booklet. For medications or equipment not obtained through a pharmacy, see the **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES** section of this Benefits Booklet.

You may review the current formulary prescription drug list on Our website at www.anthem.com/universityofcolorado, under “prescription benefits”, click on National Formulary. You may also request a copy of the formulary drug list by calling our customer service department. The drug list is subject to periodic review and amendment. Inclusion of a drug or related item on the prescription drug list is not a guarantee of coverage.

For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before We will determine Medical Necessity. We may, at Our sole discretion, establish quantity limits for specific Prescription Drugs. The PBM in consultation with Us also promotes and enforces the appropriate use of medications by reviewing for improper dosage, potential drug to drug interactions, drug-disease state interactions or drug-pregnancy interactions.

Your Copayment amount depends on whether the drug you receive a tier 1 generic or a tier 2 brand name drug. See the *Health Benefit Plan Description Form* to determine the associated Copayment for each tier. The amount of benefits paid is based upon whether you obtain covered drugs and supplies from an In-Network pharmacy or mail service program. A prescription drug must be a legend drug to be eligible for benefits.

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

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

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

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

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

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

You are limited a 30-day supply of a Prescription Drug if obtained at an In-Network pharmacy or up to a 90-day supply if received through mail order or one of the UCH retail locations noted below. For oral contraceptives, you are limited to one pill pack (normally 28 days) at an In-Network pharmacy, or three pill packs by mail order or one

of the UCH retail locations noted below. When Medically Necessary, a one-month vacation override is available with applicable Copayment and with quantity restrictions if you are traveling out of Our Service Area.

You must obtain covered prescription drugs and supplies from an In-Network pharmacy. All prescription drugs must be on Our Prescription Drug list to be eligible for benefits.

In addition to your Cost Sharing described above, if you purchase a tier 2 brand –name prescription drug when there is a FDA rated equivalent generic prescription tier 1 drug available, you are responsible for the tier 2 Copayment for the prescription drug and you will pay the difference between the cost of the brand-name prescription drug and the cost generic prescription drug. For example: a tier 2 brand name prescription costs $50; a tier 1 generic substitution is available, the tier 1 generic prescription costs $20, you pay the $30 difference plus the tier 2 brand-name Copayment not to exceed the negotiated rate of the drug. The $30 difference is not applied towards any other Cost Sharing requirement.

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

Prescription Drugs will always be dispensed as ordered by your Provider and by applicable State Pharmacy Regulations, however you may have higher Out-of-Pocket expenses. You may request, or your Provider may order, a Brand-Name drug. However, if a Generic drug is available, you will be responsible for the cost difference between the Generic and Brand-Name drug, in addition to your tier 1Generic Copayment. The cost difference between the Generic and Brand-Name drug does not contribute to your Out-of-Pocket Annual Maximum. By law, Generic and Brand-Name drugs must meet the same standards for safety, strength, and effectiveness. Using Generics generally saves money, yet provides the same quality. We reserve the right, at our discretion, to remove certain higher cost Generic drugs from this policy.

If you obtain your prescriptions at any of the following locations, your copayment will be lower than at any other retail pharmacy:

Atrium Pharmacy
12065 E 16th, Room 1054, MS A027
Aurora, CO 80045
Phone (720) 848-4083
Fax (720) 848-4084

Anschutz Outpatient Pavilion (AOP) Pharmacy
1635 Aurora Court, RM 1012, MS F702
Aurora, CO 80045
Phone (720) 848-1020
Fax (720) 848-1040

Garfield Pharmacy at Lowry
8011 E Lowry Blvd., STE 110, MS B01,
Denver, CO 80230
Phone (720) 848-9590
Fax (720) 848-9593

Delivery service for retail prescriptions is available on the Anschutz Medical Campus.

Mandatory Mail Service Program for Maintenance Drugs

If you are taking Maintenance Drugs you are limited to an initial 30 day supply and up to two subsequent 30-day refills of the Maintenance Drugs from a retail pharmacy. Within this 90 day period you must being using Our Mandatory Mail Service Program to purchase future Maintenance Drugs. A short-term drug like an antibiotic would not be considered a Maintenance Drug and therefore you could fill your prescription at a local retail pharmacy. Ordering your Maintenance Drugs through Our Mandatory Mail Service Program eliminates the need for monthly trips to the pharmacy by having your prescription delivered directly to your home. The Outpatient mail order

pharmacy benefits available under this Benefits Booklet are managed by the University of Colorado Hospital Mail Order Prescription Service at

University of Colorado Hospital
Mail Order Prescription Service
12065 E. 16th, Mail Stop A014
Aurora, Co 80045
Phone (720) 848-1432
Fax (720) 848-1433

To receive your maintenance medicine prescription by mail, follow these steps:

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

Please allow 7-10 days for processing and shipping of your order. **Helpful Tip:** We suggest that you order your refill two weeks before you need it to avoid running or of your medication. Any questions concerning the mail-order program, contact University of Colorado Hospital Mail Order Prescription Service at 720-848-1432. You will receive refill forms and a notice that shows the number of refills your doctor ordered in the package with your drugs. To order refills, you must have used 75% of your mail order prescription.

When you may need to file a claim

You may need to file your own claim if:

- You need to have a prescription filled before you receive your Health Benefit ID card; or
- Your Physician increases the amount of your dosage.

Clinical Trials

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

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

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

General Exclusions

This section indicates services, supplies, conditions, situations and charges that are excluded from coverage and are not considered Covered Services under this Benefits 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 Benefits Booklet, including but not limited to those exclusions found in the **COVERED SERVICES** section of this Benefits 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 Benefits Booklet;
2. For care received from a Out-of-Network Provider, except for Emergency Care, Urgent Care or as preauthorized by Us as a Covered Service;
3. Received from an individual or entity that is not a Provider, as defined in this Benefits Booklet;
4. That are Experimental/Investigational or related to such, whether incurred before, in connection with, or subsequent to the Experimental/Investigational service or supply, as determined by Us, in administering the Plan;
5. To the extent they are available as benefits through any governmental unit (except Medicaid), unless otherwise required by law or regulation. The payment of benefits under this Benefits Booklet will be coordinated with such governmental units to the extent required under existing state and/or federal laws;
6. For which benefits are payable under Medicare Part A, Medicare Part B and/or Medicare Part D, or would have been payable if you had applied for Medicare Part A, Medicare Part B and/or Medicare Part D, unless otherwise specified in this Benefits Booklet or as otherwise prohibited by federal law, as addressed in the section titled **Medicare** in **ADMINISTRATIVE INFORMATION;**
7. In excess of the Maximum Allowable Amount for Medical Supplies, durable medical equipment and appliances unless otherwise specified in this Benefits Booklet;
8. Incurred before your Effective Date;
9. Incurred after the termination date of this coverage unless otherwise specified in this Benefits Booklet;
10. For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Cosmetic Services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for Surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts),;
11. For services performed to maintain or preserve the present level of function or prevent regression of function for an illness, injury or condition that is resolved or stable;
12. For dental prosthesis and any treatment for teeth, gums, tooth or upper or lower jaw augmentation or reduction (orthognathic Surgery) and related service, unless otherwise specified in this Benefits Booklet;
13. Weight loss programs, whether or not they are pursued under medical or Physicians supervision, unless otherwise specified in this Benefits Booklet;
14. Treatment of obesity, including but not limited to for surgical treatment of morbid obesity (bariatric surgery/lap banding);
15. For care received in an emergency room which is not Emergency Care;
16. For research studies or screening examinations, unless otherwise specified in this Benefits Booklet;
17. For stand-by charges of a Physician;

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

42. For eyeglasses, contact lenses or their fitting, vision therapy or routine vision exams, unless otherwise specified in this Benefits Booklet;
43. For hearing aids services, unless otherwise specified in this Benefits Booklet;
44. For services or supplies primarily for educational, vocational, or training purposes, unless otherwise specified in this Benefits Booklet;
45. Services to reverse voluntarily induced sterility;
46. Services of any type for the treatment of infertility;
47. For Experimental infertility procedures and non-Medically Necessary infertility procedures including, but not limited to artificial insemination, In-Vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT);
48. For or related to services (including but not limited to speech therapy) for dysfunctions that are self-correcting such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting, learning disabilities, behavioral problems, hyperkinetic syndromes or mental retardation (except for Prescription Drugs for treatment of these conditions);
49. For personal hygiene services, self help devices that are not medical in nature, or services and supplies for comfort and convenience;
50. For care related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy;
51. Related to alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), biofeedback, chelating agents (except for treatment of heavy metal poisoning) and iridology;
52. Health club Memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas;
53. For self-help training and other forms of non-medical self care, unless otherwise specified in this Benefits Booklet;
54. For hair loss treatment, even if the hair loss is caused by a medical condition, except for alopecia areata or as otherwise specified in this Benefits Booklet;
55. For peripheral bone density scans;
56. For storage or other administrative costs, except when provided as part of the Inpatient Services and Human Organ and Tissue Transplant Services;
57. For medical, surgical services and appliances related to temporomandibular joint (TMJ) therapy regardless of Medical Necessity;
58. For the cost of donor sperm or donor eggs, storage costs for sperm or frozen embryos, or diagnostic tests to determine the effectiveness of a procedure designed to promote fertility or pregnancy;
59. Provided or billed by a residential treatment center, school, halfway house, custodial care facility for the developmentally disabled, drug and alcohol residential program , or outward bound program, even if psychotherapy is included;
60. For rolfing therapy, myotherapy or prolotherapy;
61. For ambulance transportation if you could have been transported by private automobile or by commercial or public transportation without endangering your health or safety;
62. For orthotics, orthopedic shoes and arch supports (except if you are diagnosed with diabetes);

63. For air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, wristlets, breast pumps, augmentative communication devices, surgical supports, and corsets or other articles of clothing, unless otherwise specified in this Benefits Booklet;
64. For items usually stocked in the home for general use like Band-Aids, thermometers and petroleum jelly.
65. Language training for educational, psychological or speech delays;
66. Diversional, recreational or vocational therapies such as hobbies, arts and crafts;
67. Sclerotherapy for the treatment of varicose veins in the lower extremities, including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy. Treatment of telangiectatic dermal veins (spider veins) by any method;
68. Cardiac rehabilitation home programs, on-going conditioning and maintenance;
69. For any services or supplies provided to a person not covered under the Benefits Booklet in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another women for an infertile couple;
70. For services rendered by a mobile health testing lab, except for Flu Shots.

Human Organ and Tissue Transplant Services:

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

1. Human Organ and Tissue Transplant services that are performed at any Hospital that is not designated or approved by Us for the organ or tissue being transplanted;
2. If you are not a suitable candidate as determined by the Hospital designated and approved by Us to provide Human Organ and Tissue Transplant services;
3. For donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or for their respective family Members or friends;
4. For any transplant, treatment, procedure, facility, equipment, drug, device, service or supply that requires federal or other governmental agency approval and such approval is not granted at the time services are provided, including any service or supply associated with or provided in follow-up;
5. For transplants of organs other than those listed in the **HUMAN ORGAN AND TISSUE TRANSPLANT** section of this Benefits Booklet including non-human organs;
6. Procurement of a donor organ which has been sold rather than donated;
7. Related to artificial and/or mechanical hearts or for subsequent services and supplies for a heart condition as long as any of the artificial or mechanical heart remains in place. This exclusion includes services for implantation, removal and complications.
8. For non-covered transportation and lodging.

Retail Pharmacy/Mail Order Prescription Drugs:

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

1. Non-formulary prescription drugs;
2. Prescription drugs and supplies received from an Out-of-Network pharmacy or a pharmacy who is not a UA Network pharmacy;
3. 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;
4. Non-legend prescription drugs;
5. Drugs prescribed for weight control or appetite suppression;

6. Medication or preparations used for cosmetic purposes to promote hair growth, prevent hair growth, or medicated cosmetics. These included but are not limited to Rogaine®, Viniqa®, and Tretinoin (sold under such brand names as Retin-A®);
7. Drugs not approved by the FDA;
8. Any new FDA approved drug product or technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA new drug approval or other applicable FDA approval. We may at Our sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology
9. Any medications used to treat infertility;
10. Delivery charges for prescriptions;
11. Charges for the administration of any drug unless dispensed in the Physician's office or through Home Health Care;
12. Drugs which are provided as samples to the Provider;
13. Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse;
14. Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of the **RETAIL PHARMACY/MAIL ORDER PRESCRIPTION DRUGS** section;
15. Therapeutic devices or appliances, including support garments and other nonmedicinal supplies (regardless of intended use);
16. Nonprescription and over-the-counter drugs, including herbal or homeopathic preparations, and prescription drugs that have an over-the-counter bioequivalent, even if written as a prescription;
17. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) except for injectable insulin;
18. Prescription drugs which are dispensed in quantities or refill frequency which exceed the applicable limits, established by Us, at Our sole discretion;
19. Refills of prescriptions in excess of the quantity prescribed by the Provider, or refilled more than one year from the date prescribed;
20. Prescription Drugs dispensed for the purpose of international travel;
21. Prescription Drugs which have been obtained through a Home Health Agency;
22. Replacement of lost or stolen Prescription Drugs;
23. Maintenance drugs from an UA Network retail pharmacy after a total of a 90 day supply has been purchased at an UA Network retail pharmacy – all maintenance drugs must be purchased from the University of Colorado Hospital Mail Order Prescription Service to be covered.
24. Prescription Drugs dispensed from a non-UA Network mail order pharmacy.

Clinical Trials

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

1. Any portion of the clinical trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
2. Any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
3. Extraneous expenses related to participation in the clinical trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;
4. An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;

5. Costs for the management of research relating to the clinical trial or study;
6. Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under this Benefits Booklet; or
7. Any service or procedure related to the diagnosis, treatment or prevention of complications related to a clinical trial.

Administrative Information

Premiums

How Costs are Established and Changed -As this Plan is self-funded, the Trust is responsible for paying claims covered by the Plan and responsible for paying the administrative fees to Us according to the terms of the Administrative Services Agreement. Employers may require their employees to contribute to these costs through payroll deduction. Some employer groups may choose to have Member's costs determined by the age of the Subscriber, with costs set by age brackets.

How to File Claims

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

If an Out-of-Network Provider does not bill Us directly, you must file the claim. To obtain claim forms, contact Our customer service department or obtain from our web site at www.anthem.com/universityofcolorado. You must complete the claim form and attach the itemized bill from the Provider. Balance due statements, cash register receipts and cancelled checks are not accepted. All information on the claim form and itemized bill must be readable. When traveling outside the country, you should obtain itemized bills translated to English. Charges for Covered Services should be stated in terms of United States currency. To determine the United 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Non-Contestable - This Benefits 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 Benefits 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 Benefits 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.anthem.com/universityofcolorado or contact Our customer service department.

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 Benefits 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 Benefits Booklet are for reference only and are not to be used by themselves for interpreting the provisions of the Benefits 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.

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

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

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

Workers' Compensation

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

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

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

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

- You fail to file a claim within the filing period allowed by the applicable law

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

Automobile Insurance Provisions

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

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

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

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

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

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

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

Third Party Liability: Subrogation and Right of Reimbursement

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

Subrogation

We have the right to recover, on behalf of the Trust, payments We authorized on your behalf. The following apply:

- The Trust has the first priority lien for the full amount of benefits We authorized for payment from any Recovery, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, your own insurer (for example, uninsured, underinsured, medical payments or no-fault coverage, or a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness. The Trust's first priority lien exists regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for losses and injuries.

- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights on behalf of the Trust and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover, on behalf of the Trust, the benefits paid under this Benefits Booklet.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim on behalf of the Trust and any claim still held by you, Our subrogation claim on behalf of the Trust shall be first satisfied before any part of a Recovery is applied to your claim, beneficiary's claims (if applicable), your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs incurred without Our prior written consent. You and We further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney hired regardless of whether funds recovered are used to repay benefits authorized by Us.

Right of Reimbursement

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

- You must reimburse the Trust to the extent of benefits We authorized for payment on the Member's behalf from any Recovery, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, your own insurer (for example, uninsured, underinsured, medical payments or no-fault coverage, or a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness.
- Notwithstanding any allocation made in a settlement agreement or court order, We, on behalf of the Trust, shall have a right of Recovery, in first priority, against any Recovery.
- You, your legal representative, or beneficiary must hold in trust for the Trust the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Trust immediately upon receipt of the Recovery. You, your legal representative, or beneficiary must reimburse the Trust, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you, your legal representative, or beneficiary may hire regardless of whether funds recovered are used to repay benefits paid by the Trust.

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

- The amount the Trust paid is not repaid or otherwise recovered by Us, on behalf of the Trust.
- You fail to cooperate or otherwise fulfill your duties, as described in this Benefits Booklet.
- In the event you, your legal representative, or beneficiary fails to disclose to Us the amount of any settlement, We shall be entitled to deduct the amount of the Trust's lien from any future benefit under the Benefits Booklet.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We authorized for payment or the amount of any settlement, whichever is less, directly from the providers to whom We have authorized payments, to the extent not prohibited by law. In such a circumstance, it may then be the obligation of you, your legal representative, or beneficiary to pay the provider the full outstanding amount, and We would not have any obligation to authorize payment to the provider.
- We, on behalf of the Trust, are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make to you or the recovering party whole.

The Member's Duties

- You, your legal representative, or beneficiary must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You, your legal representative, or beneficiary must cooperate with Us in the investigation, settlement and protection of the rights of the Trust.

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

NOTE: Failure to comply with obligations in this section may result in termination of coverage under this Benefits Booklet. These provisions apply when Anthem authorizes payment of benefits on behalf of the Trust as a result of injuries or illness and another party(ies) agrees or is ordered to pay money because of these injuries or when the Member received or is entitled to receive a recovery because of these injuries or illnesses.

Duplicate Coverage and Coordination of Benefits

We coordinate benefits when you have duplicate coverage.

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

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

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

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

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

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

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

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

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

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

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

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

If either form of coverage does not follow the Birthday Rule, the male policyholder's insurance is the primary plan.

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

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

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

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

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

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

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

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

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

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

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

Members with Medicare and Two Group Insurance Policies - If Medicare is secondary to a group coverage (see Medicare primacy rules), the primary coverage covering the Member will pay first, Medicare will pay second, and

the coverage covering the Member as a retiree or inactive employee or Dependent will pay third. The order of primacy is not based on the group health insurance subscriber.

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

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

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

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

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

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

Complaints, Appeals and Grievances

In administering benefits on behalf of the Trust, We have complete discretion to determine administration of benefits under this Benefits Booklet. This section explains what to do if you disagree with Our denial, in whole or in part, of a claim or requested service or supply and it includes instructions for initiating a Complaint, filing an Appeal or filing a Grievance with Us.

Complaints

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

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

Appeals

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

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

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

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

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

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

Grievances

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

HMO Colorado
Quality Management Department
700 Broadway MCCO0105-0532
Denver, CO 80273-0001

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

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 Benefits Booklet.

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

Glossary

This section defines words and terms used throughout the Benefits 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 Benefits Booklet. You should refer to this section to find out exactly how, for the purposes of this Benefits Booklet, a word or term is used, for the purposes of this Benefits Booklet.

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

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

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

Administrative Services Agreement — the agreement among Anthem Blue Cross and Blue Shield, 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 is Anthem Blue Cross and Blue Shield. The Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

Alcoholism/Substance Treatment Center — a detoxification and/or rehabilitation facility licensed by the state to treat alcoholism/drug dependency.

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

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

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

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

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

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

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

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

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

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

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 Benefits Booklet as "Anthem", "Us", "We" or "Our".

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

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

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

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

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

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

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

Benefits 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 Benefits Booklet and any other Plan document, terms of the Plan Document will control.

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

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

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

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

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

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

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

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

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

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

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

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 qualifying events. 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. The amount of Coinsurance you pay to a Provider is calculated after the determination of the Maximum Benefit Allowance, but after We subtract any discount(s) We may have negotiated with the Provider.

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

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

Complaint — an expression of dissatisfaction with Our services or the practices of a PPO Provider, Participating Provider, UA Net Provider or In-Network Provider, whether medical or non-medical in nature.

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

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

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

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

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

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

Covered Services — services, supplies or treatments which are:

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

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

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

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

Deductible — an amount that is required to be paid by you before We will begin to reimburse for services.

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

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

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

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

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

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

Effective Date — the date coverage under this Benefits Booklet begins.

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

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

Experimental/Investigational —

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

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

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

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

- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental or Investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation

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

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

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

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

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

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

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

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

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

Health Benefit Plan Description Form – the document found in the front of the Benefits Booklet, which identifies the type of coverage, Deductible, Coinsurance and Copayment information.

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

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

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

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

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

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

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

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

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

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

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

Human Organ and Tissue Transplants — a surgical process that involves the removal of an organ from one person and placement of the organ into another person. Transplant can also mean removal of body substances, such as stem cells or bone marrow, for the purpose of treatment and reimplanting the removed organ or tissue into the same person.

Individual Membership — a Membership covering one person (the Subscriber).

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

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

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

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

In-Vivo — within the living body.

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

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

Lifetime Maximum — the maximum dollar amount We will pay for Covered Services during your lifetime under Our Benefits Booklets. The Lifetime Maximum is listed on your *Health Benefit Plan Description Form.*

Long-Term Acute Care Facility (LTC) —an institution that provides an array of long-term critical care services if you have serious illnesses or injuries. Long-Term Acute Care is provided for Members with complex medical needs. These include Members with high-risk pulmonary condition who have ventilator or tracheotomy needs Members, medically unstable Members, extensive wound care needs or post operative Surgery wound care needs, and Members with low level closed head injuries. Long-Term Acute Care Facilities do not provide care for low intensity patient needs.

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

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

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

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

Maximum Allowable Amount - The maximum amount that We determine is the maximum amount payable for Covered Services you receive, up to but not to exceed charges actually billed. Our determination of a Maximum Benefit Allowance is the maximum amount We approve for any particular service. Cost Sharing amounts are based on this allowance and the amounts you pay to a Provider. Our determination considers:

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

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

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

Maximum Benefit Allowance — the maximum dollar amount We determine and approve which We allow for Covered Services and procedures.

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

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

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

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

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

- Health maintenance and preventative care
- Anticipatory guidance and health education
- Acute and chronic illness care
- Coordination of medications, specialists, and therapies

- Provider participation in hospital care; and
- Twenty-four-hour telephone care

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

Medical Supplies — items (except prescription drugs) required for the treatment of an illness or injury.

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

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

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

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

Nephritis — infection or inflammation of the kidney.

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

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

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

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

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

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

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

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

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

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

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

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

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

Participating Provider — a Facility Provider (such as a Hospital) or a Professional Provider (such as a Physician) that has entered into an agreement with Us or another Blue Cross and Blue Shield Plan to bill Us directly for Covered Services, and to accept Our Maximum Benefit Allowance as the maximum amount of payment for Covered Services the Participating Provider must bill you for or use to calculate Cost Sharing amounts for Covered Services.

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

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

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

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

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

PPO Provider — a Participating Facility Provider or a participating Professional Provider that has entered into an additional agreement with Us, to limit charges for services performed under this Benefits Booklet.

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

Prescription drugs — prescription drugs include:

> **Brand name prescription drug** — the initial version of a medication developed by a pharmaceutical manufacturer or a version marketed under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted an exclusive patent to manufacture and market a new drug for a certain number of years. After the patent expires and FDA requirements are met, any manufacturer

may produce the drug and sell the drug under its own brand name or under the drug's chemical (generic) name.

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

Generic prescription drug — drugs 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. A generic drug's active ingredients duplicate those of a brand name drug. 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 about half as much as the counterpart brand name drug.

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

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

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

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

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

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.

Primary Care Physician (PCP) — an acronym for primary care Physician, a Physician who has contracted with Us to supervise, coordinate and provide initial and basic care to you, initiate a Referral for Specialist care and maintain continuity of patient care.

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

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

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

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

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

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

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

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

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

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

Recovery – Recovery is money the Member, the Member's legal representative, or beneficiary receives whether by settlement, verdict, judgment, order or by some other monetary award or determination, from another, their insurer, or from any uninsured motorist, underinsured motorist, medical payments, no-fault, personal injury protection, or any other insurance coverage, as a result of injury or illness to the Member. Regardless of how the Member, the Member's legal representative, or beneficiary or any agreement may characterize the money received, it shall be subject to the **THIRD PARTY LIABILITY: SUBROGATION AND RIGHT OF REIMBURSEMENT** provisions of this Benefits Booklet.

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

Retail Pharmacy – an establishment licensed to dispense prescription drugs and other medications through a licensed pharmacist or mail order service upon an authorized health care professional's order.

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

Routine Patient Care (associated with clinical trials) — means all items and services that are a Covered Service under this Benefits Booklet that would be covered if the Member was not involved in either the experimental or the control arms of a clinical trial. However, such care does not include: items and services

customarily provided by the research sponsors free of charge for any enrollee in the trial; routine costs in clinical trials that include items or services that are typically provided absent a clinical trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

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

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

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

Service Area — the geographic area where we are licensed to conduct business. This plan is available throughout Colorado.

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

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

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

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

Spouse — a Subscriber's legal Spouse.

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

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

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

Sub-Acute Rehabilitation — care that includes a minimum of one hour of therapy when you cannot tolerate or does not require three hours of therapy a day. Sub-Acute Rehabilitation is generally provided in a skilled nursing facility.

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

Subscriber — the Member in whose name the Membership under the Benefits Booklet is established.

Substance Dependency — means alcoholism, drug and other substance abuse. Alcoholism and substance dependency 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 – the document found in the front of the Benefits Booklet, which identifies the type of coverage and Deductible and Coinsurance information.

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

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

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

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

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

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

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

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

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

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

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