2015

Point of Service

PPO Plan

Administered by

Anthem

BlueCross BlueShield

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

Si 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.
PART A: TYPE OF COVERAGE:1

**IN-NETWORK:**
**PARTICIPATING PROVIDERS:** You will have access to a National Blue Cross and Blue Shield PPO Network. Your benefit will be the highest level when you receive covered services from a participating provider. (You are responsible for any applicable copayments and coinsurance). Anthem Blue Cross and Blue Shield will pay the participating provider directly.

**OUT-OF-NETWORK:**
**NON-PARTICIPATING PROVIDERS:** Non-participating facilities or providers have not entered into any agreement with Anthem Blue Cross and Blue Shield. They may bill Anthem Blue Cross and Blue Shield or the patient. Anthem Blue Cross and Blue Shield will pay you. **It is your responsibility to pay the non-participating providers.**

PART B: SUMMARY OF BENEFITS

**Important Note:** This and the following pages contain a limited description of the coverage available through this group plan. Coverage is governed at all times by the complete terms of the Master Group Insurance Policy issued to Colorado State University. This Benefit Booklet is available online at [http://hrs.colostate.edu/benefits/fap-insplans-new.pdf](http://hrs.colostate.edu/benefits/fap-insplans-new.pdf). This group major medical plan is self-insured by Colorado State University and is administered by Anthem Blue Cross and Blue Shield.

<table>
<thead>
<tr>
<th>1. ANNUAL DEDUCTIBLE</th>
<th>PPO (PARTICIPATING) Providers (In-Network)</th>
<th>Non-PARTICIPATING Providers (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Individual</td>
<td>None</td>
<td>$500</td>
</tr>
<tr>
<td>b) Family</td>
<td>None</td>
<td>$1,000 for all family members.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No one family member may meet more than $500 of the $1,000 family deductible.</td>
</tr>
</tbody>
</table>
2. **COINSURANCE/COPAYMENTS**

<table>
<thead>
<tr>
<th>PPO (PARTICIPATING) Providers (In-Network)</th>
<th>Non-PARTICIPATING Providers (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coinsurance:</strong> Refer to the below benefits for specific details. Coinsurance is required up to the out-of-pocket annual maximum.</td>
<td><strong>Coinsurance:</strong> 70% or 90% after deductible. Coinsurance is required up to the out-of-pocket annual maximum. Subject to certain exclusions as identified below.</td>
</tr>
<tr>
<td><strong>Copayments:</strong> Refer to the below benefits for specific details.</td>
<td><strong>Copayments:</strong> Does not apply</td>
</tr>
<tr>
<td>Coinsurance options reflect the amount the Plan will pay. The difference between what the Plan pays and 100% is the amount you pay. All copayments are the amounts you pay.</td>
<td>Coinsurance options reflect the amount the Plan will pay. The difference between what the Plan pays and 100% is the amount you pay. All copayments are the amounts you pay. For non-participating providers you also pay the difference between Anthem’s maximum allowed amount and the amount billed by the non-participating provider.</td>
</tr>
</tbody>
</table>

3. **OUT-OF-POCKET ANNUAL MAXIMUM**

<table>
<thead>
<tr>
<th>a) Individual</th>
<th>b) Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>• $1,250 in coinsurance, <em>plus</em></td>
<td>• $2,500 in coinsurance, <em>plus</em></td>
</tr>
<tr>
<td>• Copayments, <em>plus</em></td>
<td>• Copayments, <em>plus</em></td>
</tr>
<tr>
<td>No one family member may meet more than $1,250 of the $2,500 family out-of-pocket annual maximum.</td>
<td>No one family member may meet more than $3,000 of the $6,000 family out-of-pocket annual maximum.</td>
</tr>
</tbody>
</table>

4. **LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE**

<table>
<thead>
<tr>
<th>PPO (PARTICIPATING) Providers (In-Network)</th>
<th>Non-PARTICIPATING Providers (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No lifetime maximum</td>
<td>No lifetime maximum</td>
</tr>
</tbody>
</table>

5. **COVERED PROVIDERS**

<table>
<thead>
<tr>
<th>PPO (PARTICIPATING) Providers (In-Network)</th>
<th>Non-PARTICIPATING Providers (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem Blue Cross and Blue Shield PPO Provider Network. See provider directory for complete list or refer to <a href="http://www.anthem.com">www.anthem.com</a> or refer to <a href="http://www.bluecares.com">www.bluecares.com</a> for providers outside the state of Colorado.</td>
<td>All providers licensed or certified to provide covered benefits.</td>
</tr>
</tbody>
</table>

6. **ROUTINE MEDICAL OFFICE VISITS**

<table>
<thead>
<tr>
<th>PPO (PARTICIPATING) Providers (In-Network)</th>
<th>Non-PARTICIPATING Providers (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered in full after $15 per office visit copayment and 90% for laboratory and x-ray services. Copayment does not apply if an office visit is not billed.</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td><strong>PREVENTIVE CARE</strong></td>
</tr>
<tr>
<td>---</td>
<td>-------------------</td>
</tr>
<tr>
<td>7.</td>
<td>a) Well baby services (0 up to 12 months)</td>
</tr>
<tr>
<td></td>
<td>b) Children’s services</td>
</tr>
<tr>
<td></td>
<td>c) Adults’ services</td>
</tr>
<tr>
<td></td>
<td><strong>MATERITY</strong></td>
</tr>
<tr>
<td>8.</td>
<td>a) Prenatal care</td>
</tr>
<tr>
<td></td>
<td>b) Delivery &amp; inpatient well baby care</td>
</tr>
</tbody>
</table>
9. **PRESCRIPTION DRUGS**

<table>
<thead>
<tr>
<th>PPO (PARTICIPATING) Providers (In-Network)</th>
<th>Non-PARTICIPATING Providers (Out-of-Network)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Retail Pharmacy:</strong> Participating pharmacy (34-day supply)</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Specialty Pharmacy:</strong> Participating pharmacy (34-day supply). Specialty pharmacy drugs often require special handling such as temperature controlled packaging and overnight delivery and are unavailable at a retail pharmacy or through the mail order service. Benefits are only provided when you receive services from a specialty pharmacy as determined by Anthem for those specialty pharmacy drugs included on Anthem's specialty drug list.</td>
<td></td>
</tr>
<tr>
<td><strong>Copayments for retail pharmacy and specialty pharmacy:</strong> Tier 1 $10 copayment for each 34-day supply Tier 2 $20 copayment for each 34-day supply Tier 3 $40 copayment for each 34-day supply</td>
<td></td>
</tr>
<tr>
<td><strong>Mail order service:</strong> (90-day supply maximum) <strong>Copayments for mail order service:</strong> Tier 1 $20 copayment for each 90-day supply Tier 2 $40 copayment for each 90-day supply Tier 3 $80 copayment for each 90-day supply</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs will always be dispensed as ordered by your provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket expenses. You may request, or your provider may order, the brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and brand-name drug, in addition to your tier 1 copayment. By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness. Anthem reserves the right, at our discretion, to remove certain higher cost generic drugs from this policy. For drugs on our approved list, contact Customer Service at 303-831-2020 or 1-800-542-9402 or access our web site at <a href="http://www.anthemprescription.com">www.anthemprescription.com</a>.</td>
<td></td>
</tr>
<tr>
<td><strong>Smoking Cessation Prescription Drugs:</strong> Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem.</td>
<td></td>
</tr>
<tr>
<td><strong>Birth Control:</strong> Oral, injection and contraceptive devices obtained by a physician’s prescription are covered at 100%</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs are covered only when received from a participating pharmacy, participating specialty pharmacy or participating mail order service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PPO (PARTICIPATING) Providers (In-Network)</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>10. INPATIENT HOSPITAL</strong></td>
<td>90% after $125 per admission copayment Pre-certification from Anthem BCBS must be received <strong>before a hospital admission or within 5 days</strong> after an emergency admission for full benefits to be payable. Consultation for a second opinion (and third if necessary) is paid at 100%.</td>
</tr>
<tr>
<td><strong>11. OUTPATIENT/AMBULATORY SURGERY</strong></td>
<td>90% after $125 per admission copayment. This includes colonoscopies with a medical diagnosis.</td>
</tr>
<tr>
<td><strong>12. LABORATORY AND X-RAY</strong></td>
<td>90%</td>
</tr>
<tr>
<td><strong>13. EMERGENCY CARE</strong></td>
<td>90% after $60 copayment per emergency room visit, applied to inpatient hospital copayment if admitted.</td>
</tr>
<tr>
<td><strong>14. AMBULANCE</strong></td>
<td>90% after $60 per trip copayment</td>
</tr>
<tr>
<td></td>
<td>90% after $125 per trip copayment</td>
</tr>
<tr>
<td><strong>15. URGENT, NON-ROUTINE, AFTER HOURS CARE</strong></td>
<td>90% after $125 per admission copayment</td>
</tr>
<tr>
<td></td>
<td>Covered in full after $15 per office visit copayment and 90% for laboratory and x-ray services. Copayment does not apply if an office visit is not billed.</td>
</tr>
<tr>
<td><strong>16. BIOLOGICALLY-BASED MENTAL ILLNESS CARE</strong></td>
<td>Coverage is no less extensive than the coverage provided for any other physical illness.</td>
</tr>
<tr>
<td><strong>17. OTHER MENTAL HEALTH CARE</strong></td>
<td>90% after $125 per admission copayment</td>
</tr>
<tr>
<td></td>
<td>90% after $15 per office visit copayment</td>
</tr>
<tr>
<td></td>
<td>Copayments for other mental health care do not go towards meeting your out-of-pocket annual maximum.</td>
</tr>
<tr>
<td></td>
<td>Contact the behavioral health administrator at 1-800-424-4014 for information on how to locate a provider and your benefits.</td>
</tr>
<tr>
<td>18. ALCOHOL &amp; SUBSTANCE ABUSE</td>
<td>PPO (PARTICIPATING) Providers (In-Network)</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>a) Inpatient Care</td>
<td>Alcohol abuse: 90% after $125 per admission copayment</td>
</tr>
<tr>
<td>b) Outpatient care</td>
<td>Substance abuse: 90% after $125 per admission copayment</td>
</tr>
<tr>
<td></td>
<td>Alcohol and substance abuse: 90% after $15 per office visit copayment</td>
</tr>
<tr>
<td></td>
<td>Copayments for other alcohol and substance abuse care does not go towards meeting your out-of-pocket annual maximum.</td>
</tr>
<tr>
<td></td>
<td>Contact the behavioral health administrator at 1-800-424-4014 for information on how to locate a provider and/or your benefits.</td>
</tr>
<tr>
<td>19. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY</td>
<td>90% after $125 per admission copayment</td>
</tr>
<tr>
<td>a) Inpatient</td>
<td>90% after $15 per office visit copayment (See Benefit Booklet for definitions, limitations, and exclusions).</td>
</tr>
<tr>
<td>b) Outpatient</td>
<td>90% after $15 per office visit copayment (See Benefit Booklet for definitions, limitations, and exclusions).</td>
</tr>
<tr>
<td>20. DURABLE MEDICAL EQUIPMENT</td>
<td>90%</td>
</tr>
<tr>
<td>21. OXYGEN</td>
<td>90%</td>
</tr>
<tr>
<td>22. ORGAN TRANSPLANTS&lt;sup&gt;5&lt;/sup&gt;</td>
<td>90% after $125 per admission copayment (includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow and peripheral stem cell). &lt;sup&gt;Pre-certification required.&lt;/sup&gt;</td>
</tr>
<tr>
<td>23. HOME HEALTH CARE</td>
<td>Covered in full after $15 per visit copayment (up to 100 visits per calendar year).</td>
</tr>
<tr>
<td>24. HOSPICE CARE</td>
<td>Covered in full</td>
</tr>
<tr>
<td>25. SKILLED NURSING FACILITY CARE</td>
<td>90% after $125 per admission copayment (up to 100 days per calendar year in and out-of-network combined) copayment waived if admitted directly to skilled nursing facility from an inpatient acute facility.</td>
</tr>
<tr>
<td>26. VISION CARE</td>
<td>Covered in full after $15 per office visit copayment (limited to one exam per calendar year, eyeglass hardware not covered).</td>
</tr>
<tr>
<td>27. CHIROPRACTIC CARE</td>
<td>Covered in full after $15 per visit copayment (up to 20 visits per calendar year) and 90% for laboratory and x-ray services.</td>
</tr>
<tr>
<td>28. RETAIL HEALTH CLINIC VISITS</td>
<td>Covered in full after $15 per office visit copayment and 90% for laboratory and x-ray services</td>
</tr>
<tr>
<td>29. SIGNIFICANT ADDITIONAL COVERED SERVICES</td>
<td>Treatment of Autism Spectrum Disorders Benefit level determined by type of service provided.</td>
</tr>
<tr>
<td>PPO (PARTICIPATING) Providers (In-Network)</td>
<td>Non-PARTICIPATING Providers (Out-of-Network)</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>The following annual maximums, based on calendar year, are effective for applied behavior analysis services for In and Out-of-Network services combined. We may exceed these maximums if required by law:</td>
<td>The following annual maximums, based on calendar year, are effective for applied behavior analysis services for In and Out-of-Network services combined. We may exceed these maximums if required by law:</td>
</tr>
<tr>
<td>• From birth to age eight (up to Member’s ninth birthday): 550 sessions of 25 minutes for each session In and Out-of-Network combined</td>
<td>• From birth to age eight (up to Member’s ninth birthday): 550 sessions of 25 minutes for each session In and Out-of-Network combined</td>
</tr>
<tr>
<td>• Age nine to age eighteen (up to Member’s nineteenth birthday): 185 sessions of 25 minutes for each session In and Out-of-Network combined</td>
<td>• Age nine to age eighteen (up to Member’s nineteenth birthday): 185 sessions of 25 minutes for each session In and Out-of-Network combined</td>
</tr>
<tr>
<td>When a member desires another professional opinion, they may obtain a second surgical opinion.</td>
<td>When a member desires another professional opinion, they may obtain a second surgical opinion.</td>
</tr>
</tbody>
</table>

1 "Network" refers to a specified group of physicians, hospital, medical clinics and other medical care providers that your Plan may require you to use in order to get any coverage at all under the Plan, or that the Plan may encourage you to use because it pays 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 "Out-of-pocket maximum" The maximum amount you will have to pay for allowable covered expenses under a medical Plan, which may or may not include the deductible or copayments, depending on the contract for that Plan.

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

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

5 Transplants will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.

Grandfathered Health Plan

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

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

We are pleased to welcome you as a member of the Colorado State University (CSU) Point-of-Service PPO Plan administered by Anthem Blue Cross and Blue Shield. You have enrolled in a quality self-funded health benefit Plan that, pursuant to the terms of this benefit booklet, pays for many of your health care expenses, including most expenses for physician and outpatient care, emergency care and hospital inpatient care. As your health benefit Plan is self-funded, your employer is responsible for the payment of claims. Anthem is not acting as an insurer, but instead is administering the benefits on behalf of the employer.

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

For questions about how your benefits are administered, please call Our Member Services department between the hours of 7:30 a.m. and 5:30 p.m. Mountain Time, Monday through Friday, or visit Our website. The local and toll-free Member Services numbers and Our website address are conveniently printed at the bottom of every page of this benefit booklet.

Thank you for selecting Anthem Blue Cross and Blue Shield for administering your health care benefits. We wish you good health.

Mike Ramseier
President and General Manager
Anthem Blue Cross and Blue Shield
Acceptance of benefits under this benefit booklet constitutes acceptance of its terms, conditions, limitations and exclusions. Members are bound by all of the terms of this benefit booklet.

Your health benefits are defined in the following documents:

- This benefit booklet, the *Summary of Benefits* and any amendments or endorsements thereto.
- The online enrollment system 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 Plan:

- The Employer Master Application.
- The Employer Master Contract or Administrative Services Agreement between Anthem and the employer.

Anthem, or anyone acting on Our behalf, will generally determine how benefits will be administered and who is eligible for participation in a manner that is consistent with the terms of this benefit booklet. In the event of any question as to the interpretation of any provision of this benefit booklet, Anthem’s determination will be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are medically necessary, experimental/investigative, or, in the case of surgery, cosmetic. However, a member may utilize all applicable complaint, grievance and appeal procedures available under this benefit booklet.

This benefit booklet is not a Medicare Supplement policy.
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Member 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 Provider 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.
- Tell your Doctors or other health care Providers if you don’t understand any type of care you’re getting or what they want you to do as part of your care plan.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let Our Member Services 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.
Member Rights and Responsibilities

Anthem is committed to providing quality benefits and Member Services to Our members. Benefits and coverage for services provided under the benefit program are governed by the benefit booklet and not by this Member Rights and Responsibilities statement.

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

If you need more information or would like to contact Us, please go to www.anthem.com and select Customer Support > Contact Us. Or call the members services number on your Health Benefit ID Card.

How to Obtain Language Assistance

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

This is a Preferred Provider Organization (PPO) health benefit Plan, which means members have in-network (participating) and out-of-network (non-participating) benefits.

This PPO Plan offers great flexibility because members may choose how to use their benefits and to control their out-of-pocket expenses. When members receive care from in-network providers, they receive the highest level of benefits at the lowest cost. The Summary of Benefits lists payment levels for both in-network and out-of-network care. Anthem publishes a directory of participating providers. You may call the Member Services number that is listed on your identification card or you may write Anthem and ask them to send you a directory. You may also search for a provider online at www.anthem.com.

Providers

Participating Providers (In-Network)

Participating providers have entered into a network agreement with Anthem for this specific health benefit program. Covered services provided by a participating provider are considered in-network. When you visit a participating provider you have lower out-of-pocket expenses. Your in-network cost sharing responsibilities to participating providers may be found on the Summary of Benefits under the IN-NETWORK heading. You are responsible for determining if your provider is a participating provider. You may visit Anthem’s website or call their Member Services department for information about provider network participation.

Anthem makes no guarantee that a participating provider will be available for all services and supplies covered under your PPO coverage. For a limited number of services and supplies, Anthem may not have arrangements with participating providers. Please call Anthem’s Member Services department for a list of the counties where they may not have participating providers for such services and supplies.

In some circumstances (excluding emergency services), Anthem may require that you travel a reasonable distance for care within their provider network to receive services from a participating provider. If you knowingly choose to obtain the service from a non-participating provider rather than the participating provider, you will be responsible for paying any charges from the non-participating provider that exceed the maximum allowed amount. Anthem will not deny or restrict covered services solely because you obtain treatment from a non-participating provider; however, you may have a higher financial responsibility.

Anthem makes no guarantee that a PPO provider will be available for all services and supplies covered under the member’s PPO benefits. For a limited number of services and supplies, Anthem does not have arrangements with PPO providers. The counties in which Anthem does not have PPO providers for such services and supplies can be obtained by calling Our Member Services department. If Anthem does not have a PPO provider for a covered service and Anthem does not inform the member of an alternative for obtaining the service from a non-PPO contracted provider or non-contracted provider, the member may seek service from a non-PPO contracted or non-contracted provider, and the member will pay no more than what the member would have paid for such covered service if it had been received from a PPO provider. However, in some circumstances Anthem may require the member to travel up to 100 miles for care within Our provider network to receive services from a PPO or non-PPO contracted provider. Under these circumstances, if the member knowingly chooses to obtain the service from a non-contracted provider rather than the PPO or non-PPO contracted provider, the member will be responsible for paying any charges from the non-contracted provider that exceed the maximum benefit allowance paid by Anthem to the provider. Anthem will not deny or restrict PPO covered services solely because the member obtains treatment from a non-PPO contracted provider or non-contracted provider; however, the member may have a higher financial responsibility for those services.

If you do not receive a preauthorized network exception to obtain covered services from a non-participating provider, the claim will be processed using your out-of-network cost shares.
Non-Participating Providers (Out-of-Network)

Providers who have not signed a PPO provider contract with Anthem are non-participating providers under this PPO plan. Services provided by a non-participating provider are considered out-of-network. When you visit a non-participating provider you may have higher out-of-pocket expenses. Your out-of-network cost sharing responsibilities for non-participating providers may be found on the Summary of Benefits under the “out-of-network” heading.

Anthem will pay the benefits of this benefit booklet directly to non-participating providers, depending on whether you have authorized assignment of benefits. Anthem may require a copy of the assignment of benefits for their records. These payments fulfill Anthem’s obligation to you for those services.

Cost Sharing Requirements

Cost sharing refers to how Anthem, on behalf of the employer and members, shares the cost of health care services. It describes what Anthem on behalf of the employer is responsible for paying and what the member is responsible for paying. Members meet their cost sharing requirements through the payment of copayments, deductibles, and coinsurance (as described below) depending upon the terms of their benefits. Cost sharing requirements depend upon the choices the member makes in accessing services. For example, if the member chooses to use a participating provider or participating facility, the member’s out-of-pocket expenses may be less than if the member chooses a non-participating provider or non-participating facility.

Anthem has worked with physicians, hospitals, pharmacies and other health care providers to control health care costs. As part of this effort, many providers agree to control costs by giving discounts to Anthem. Most other insurers maintain similar arrangements with providers.

In their contracts, participating providers agree to accept Anthem’s maximum allowed amount as payment in full for covered services. Anthem determines a maximum allowed amount for all procedures performed by providers.

If a member uses a non-participating provider, any amount over the maximum allowed amount is the member’s responsibility and does not apply toward the deductible or out-of-pocket annual maximum.

Maximum Allowed Amount

This section describes how Anthem determines the amount of reimbursement for covered services. Reimbursement for services rendered by participating and non-participating providers is based on your Plan’s maximum allowed amount for the covered service that you receive. Please see BlueCard as described in the ADMINISTRATIVE SERVICES section under How to File Claims for additional information.

The maximum allowed amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Anthem’s definition of covered services, to the extent such services and supplies are covered under the terms of this benefit booklet and are not excluded;
- that are medically necessary; and
- that are provided in accordance with all applicable pre-certification, utilization management or other requirements set forth in this benefit booklet.

You will be required to pay a portion of the maximum allowed amount to the extent you have not met your deductible or coinsurance. In addition, when you receive covered services from a non-participating provider, you may be responsible for paying any difference between the maximum allowed amount and the provider’s actual charges. This amount can be significant.

When you receive covered services from a provider, Anthem will, to the extent applicable, apply claim processing rules to the claim submitted for those covered services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Anthem’s determination of the maximum allowed amount. Anthem’s application of these rules does not mean that the covered services you receive were not medically necessary. It means Anthem has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies.
For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the maximum allowed amount will be based on the single procedure code rather than a separate maximum allowed amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other healthcare professional, Anthem may reduce the maximum allowed amounts for those secondary and subsequent procedures because reimbursement at 100 percent of the maximum allowed amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

**Provider Network Status**

The maximum allowed amount may vary depending upon whether the provider is a participating provider or a non-participating provider.

A participating provider is a provider who is in the provider network for this specific health benefits program. For covered services performed by a participating provider, the maximum allowed amount for this plan is the rate the provider has agreed with Anthem to accept as reimbursement for the covered service. Because participating providers have agreed to accept the maximum allowed amount as payment in full for those covered services, they should not send you a bill or collect for amounts above the maximum allowed amount. However, you may receive a bill or be asked to pay all or a portion of the maximum allowed amount to the extent you have not met your deductible or coinsurance. Please call Member Services for help in finding a participating provider or visit www.anthem.com.

Providers who have not entered into a PPO Provider contract with Us are non-participating Providers and are not in any of Our networks subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For covered services you receive from a non-participating provider, the maximum allowed amount for this Plan will be one of the following as determined by Anthem:

1. An amount based on Anthem’s non-participating provider fee schedule/rate, which Anthem has established in their discretion, and which Anthem reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, We will update such information, which is unadjusted for geographic locality, no less than annually; or

3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers’ fees and costs to deliver care; or

4. An amount negotiated by Anthem or a third party vendor which has been agreed to by the provider. This may include rates for services coordinated through case management; or

5. An amount based on or derived from the total charges billed by the non-participating Provider.

Unlike participating providers, non-participating providers may send you a bill and collect for the amount of the provider’s charge that exceeds Anthem’s maximum allowed amount. You are responsible for paying the difference between the maximum allowed amount and the provider charges. This amount can be significant. Choosing a participating provider will likely result in lower out-of-pocket costs to you. Please call Member Services for help in finding a participating provider or visit Our website at www.anthem.com.

**Member Services** is also available to assist you in determining your plan’s maximum allowed amount for a particular service from a non-participating provider. In order for Anthem to assist you, you will need to obtain from your provider, the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider’s charges to calculate your out-of-pocket responsibility. Although Member Services can
assist you with this pre-service information, the final maximum allowed amount for your claim will be based on the actual claim submitted by the provider.

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

Member Cost Share
For certain covered services and depending on your health benefits program, you may be required to pay a part of the maximum allowed amount as your cost share amount (for example, deductible and/or coinsurance).

Your cost share amount and out-of-pocket limits may vary depending on whether you receive services from a participating or non-participating provider. Specifically, you may be required to pay higher cost share amounts or may have limits on your benefits when using non-participating providers. Please see the Summary of Benefits for your cost share responsibilities and limitations, or call Member Services to learn how your health benefit coverage or cost share amounts may vary by the type of provider you use.

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

In some instances you may only be asked to pay the lower in-network cost sharing amount when you use a non-participating provider. For example, if you go to an in-network/participating hospital or provider facility and receive covered services from a non-participating provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a participating hospital or facility, you will pay the in-network cost share amounts for those covered services, and you will not be required to pay more for the services than if the services had been received from a participating provider.

Under certain circumstances, if Anthem pays the provider amounts that are your responsibility, such as deductibles or coinsurance, Anthem may collect such amounts directly from you. You agree that Anthem has the right to collect such amounts from you.

Authorized Services
In some circumstances, such as where there is no in-network provider or participating provider available for the covered service, Anthem may authorize the in-network cost share amounts (deductible and/or coinsurance) to apply to a claim for a covered service you receive from a non-participating provider. In such circumstance, you must contact Anthem in advance of obtaining the covered service. Please contact Member Services at the phone number as indicated on your ID card to request authorization.

Copayment
Copayments may be required for covered services. A copayment is a predetermined, fixed-dollar amount a member must pay to receive a specific service. Members are required to pay a copayment to providers for specific services as listed on the Summary of Benefits. Members are responsible for making copayments directly to the provider. Members must pay copayment amounts even after meeting deductible and/or coinsurance requirements. Copayment amounts do not apply to deductible and/or coinsurance requirements. In addition to any copayment required, members are responsible for any applicable deductible and/or coinsurance for additional services received, e.g., laboratory and X-ray services.

Deductible
A deductible is a specified amount of expense for covered services that the member must pay within each member’s benefit year before the Plan provides benefits. The deductible amount is listed on the Summary of Benefits.

There is a deductible for out-of-network providers only. If a service, e.g., an office visit or inpatient hospital care, is subject to a copayment, that service is not subject to the deductible, i.e., ambulance services. However, additional services such as laboratory and X-ray services may be subject to the deductible. Each member must meet a separate deductible. A new deductible is required for each member’s benefit year.

**Family Deductible** - Under a family membership, the family deductible amount is met as follows: When one family member meets one-half of the family deductible, that family member is eligible for benefits. The remaining family members are eligible for benefits when they individually satisfy their individual deductibles or collectively satisfy the balance of the family deductible.

When no family member meets one-half of the family deductible, but the family members collectively meet the entire family deductible, then all family members will be eligible for benefits.

The family deductible is also applicable for newborn and adopted children for the first 31-day period following birth or adoption if the child is enrolled or not enrolled within 30 days from the date of birth or placement for adoption.

**Coinsurance/Out-of-Pocket Maximum**

For in-network and out-of-network covered services, members pay coinsurance until the out-of-pocket annual maximum is reached for the member’s benefit year. Until the out-of-pocket maximum is reached, the Plan pays the remaining percentage. Once the out-of-pocket annual maximum is reached, the Plan pays 100 percent of any remaining eligible charges for the remainder of the member’s benefit year. For non-participating providers the deductible must first be met before coinsurance will be applied. Members have separate out-of-pocket annual maximums for medical services, other mental health care, alcohol and substance abuse care. The Summary of Benefits details what charges count towards the out-of-pocket annual maximum.

A member will always be responsible for the difference between billed charges and the maximum allowed amount for non-participating providers, even after reaching the out-of-pocket annual maximum for out-of-network services. The difference between billed charges and the maximum allowed amount for non-participating providers does not contribute towards your out-of-pocket annual maximum.

**NOTE:** No one family member may contribute more than the member’s individual coinsurance maximum toward meeting the family out-of-pocket annual maximum. A member will always be responsible for the difference between billed charges and the maximum allowed amount for non-participating providers, even after reaching the out-of-pocket annual maximum for out-of-network services.

The family membership out-of-pocket annual maximum is also applicable for newborn and adopted children for the first 31-day period following birth or adoption if the child is enrolled or not enrolled within 30 days from the date of birth or placement for adoption.

Some services are not subject to coinsurance. The required coinsurance percentages are listed on the Summary of Benefits.

**Benefit Period Maximum**

Some covered services have a maximum number of days, visits or dollar amounts that Anthem will allow during a member’s benefit year. When the deductible is applied to a covered service which has a maximum number of days or visits, the maximum benefits may be reduced by the amount applied to the deductible. These maximums apply even if you have satisfied the applicable out-of-pocket annual maximum. See the Summary of Benefits for those services which have a benefit period maximum.

**Maximum Lifetime Benefits**

Under this benefit design, the lifetime payment is unlimited.
Managed Care Features

Managed care is Our way of giving you access to quality, cost effective health care. It uses tools like utilization management and cost of services, and measures Provider and coverage performance. Your health benefit plan includes the processes of Pre-certification, concurrent and retrospective reviews to determine when services should be covered by your health benefit plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your health benefit plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. This section of the Booklet explains how these managed care features are used and will guide you through the steps to get care. For more information on what to do for Emergency care and Urgent Care, please see the “Benefits/Coverage (What Is Covered)” section.

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

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

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

You may determine whether a Provider is Participating in certain programs by checking your Provider directory or contacting member services at the number on the back of your Health Benefit ID card.

This benefit booklet does not restrict or interfere with the right of any member entitled to service and care in a hospital, to select a hospital or to choose an attending physician. Anthem requires that physicians hold a valid physician’s license, practice within the scope of that license and be a member of, or acceptable to, the attending staff and board of directors of the hospital in which the services are to be provided.

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

Benefits provided under this Plan do not regulate the amounts charged by providers of medical care.

Anthem’s Process to Determine Whether Services are Covered

To determine whether a health care service is a covered benefit, Anthem considers whether the service is medically necessary and whether the service is experimental/investigational or cosmetic and is otherwise not excluded under this benefit booklet. Anthem uses numerous resources, including current peer-reviewed medical literature, Anthem’s adopted medical policies and practice guidelines, guidelines obtained from recognized national organizations and professional associations and consultations with physician specialists to determine whether a particular service is covered. Anthem will assist the member by determining what services are covered under the member’s chosen level of benefits and what services are excluded.

In administering benefits on behalf of the employer, Anthem determines whether services, procedures, supplies or visits are medically necessary. Medically necessary services, procedures, supplies or visits and preventive care are examples of the member’s covered benefits. Anthem uses medical policy, medical practice guidelines, professional standards and outside medical peer review to determine medical necessity. Anthem’s 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 Anthem reserves the right to periodically review and update medical policies. Providers and members may go to Our website to view a list of services that are considered medically necessary. The benefits, exclusions and limitations of a member’s benefit booklet take precedence over medical policy.
About Your Health Benefits

Experimental/Investigational and/or Cosmetic Procedures

In administering benefits on behalf of the employer, Anthem will not pay for any services, procedures, surgeries or supplies that Anthem considers experimental/investigational and/or cosmetic. Providers and members may go to Anthem’s website and select “Physicians and Providers/Colorado/Anthem Medical Policies” to view services, procedures, surgeries and supplies that Anthem considers experimental/investigational and/or cosmetic.

Appropriate Place and Pre-certification

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 benefit booklet covers care received in both environments provided the care received is appropriate to the setting and is medically necessary. Inpatient settings include hospitals and skilled nursing facilities. Outpatient settings include physicians’ offices and ambulatory surgery centers.

Pre-certification is a process Anthem uses to ensure a member’s care is provided in the most medically appropriate setting. The pre-certification process may set limits on the care to be given. Pre-certification is required prior to an admission to a hospital or before receiving certain procedures or services. Some drugs also require pre-certification.

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

The in-state participating provider who schedules an admission or orders the procedure or service is responsible for obtaining pre-certification. For non-emergency services from an in-state non-participating provider or out-of-state PPO provider, out-of-state participating provider, or out-of-state non-participating provider, the member must ask the physician to obtain pre-certification. To determine which services and/or drugs require pre-certification, and/or to be sure that pre-certification has been obtained, the member may contact Anthem. Our Member Services department telephone number and website address are located on the bottom of each page of this benefit booklet.

Inpatient Admissions - Inpatient admissions require pre-certification prior to a member’s admission to a facility. The member’s health care provider must call the number for Provider Authorization on the member’s health benefit ID card to request pre-certification. Anthem will review the request for pre-certification. If the inpatient stay is approved, all benefits available under the member’s benefit booklet are provided. More information can be found in the MEMBER BENEFITS section. Anthem initially authorizes a specified number of days for the inpatient stay and reevaluates such authorization if additional days are requested by the health care provider. This process facilitates timely discharge or transfer of the member to the appropriate level of care.

If Anthem does not grant pre-certification, the member will be held financially responsible for all inpatient stay charges. The member or the member’s representative may appeal Our pre-certification decision by following the procedure outlined in the COMPLAINTS, APPEALS AND GRIEVANCES section of this benefit booklet.

Scheduled Admissions - The member’s health care provider must obtain pre-certification from Anthem for all scheduled inpatient admissions. Pre-certification must be requested from Anthem at least seven days prior to admission. Anthem will send written confirmation of Anthem’s decision to the member and the health care provider within two business days of receipt of all necessary information.

 Unscheduled (Emergency) Admissions - Anthem requires notification of an unscheduled (emergency) admission within 5 days after the admission. The member is responsible for ensuring that Anthem has been notified of the unscheduled admission unless the member is unable to do so. Examples of unscheduled or emergency admissions include admissions involving accidents or onset of premature labor in pregnancy. Failure to notify Anthem may result in a reduction or denial of benefits.

Outpatient Admissions - The member’s health care provider must contact Anthem for pre-certification of many services performed on an outpatient basis. Members may go to Anthem’s website or call Anthem’s Member Services department for a list of outpatient procedures and services that require pre-certification. These services may be performed in a hospital on an outpatient basis or in a freestanding facility, such as an ambulatory surgery center.
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Upon receipt of a pre-certification request, Anthem may require additional information to determine medical necessity. Anthem will send written confirmation of Anthem’s decision to the member and the health care provider within two business days of Anthem’s receipt of all necessary information. The pre-certification will be valid only for a specific period of time and place. The member must obtain the requested service within the time allotted in the pre-certification and at the place authorized. If the pre-certification period expires, or if additional services are requested, the provider must contact Anthem to request another authorization.

A pre-certification that a service requested meets medical necessity criteria does not guarantee that payment will be allowed. Fraud or abuse could cause a denial of payment. When Anthem receives the member’s claim(s), Anthem will review them against the terms of this benefit booklet.

The member or the member’s representative may appeal our pre-certification decision by following the procedure outlined in the COMPLAINTS, APPEALS AND GRIEVANCES section.

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

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

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

Note: If We do not request additional information or provide notification of approval or denial as required by applicable law, the request will be deemed approved. We will provide you, the prescribing Provider, and the dispensing pharmacy with confirmation of the approval within one business day of the date the request was deemed approved.

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

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

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

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

- Two business days of the receipt of an electronically filed non-urgent prior authorization request, as required by applicable law, the request will be deemed approved. We will provide you, the prescribing Provider, and the dispensing pharmacy with confirmation of the approval within two business days of the date the request was deemed approved; or

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

Appropriate Length of Stay

Anthem, in conjunction with the member’s providers, determines the appropriate length of an inpatient hospital stay for which benefits will be paid for members by using medical policies and medical care guidelines, such as inpatient and surgical care optimal recovery guidelines. With the use of these guidelines and increasing your familiarity with your benefit plan, the member is more likely to receive the appropriate level of care and achieve favorable outcomes.

Concurrent Review

While a member is in the hospital, the member’s medical care will be reviewed to determine whether the member is receiving appropriate and medically necessary hospital services. If the member has an unscheduled admission to the hospital for any reason, including a medical emergency, maternity care, alcoholism detoxification, or substance abuse care, Anthem requires notification within 5 days 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, Anthem may determine that further hospitalization is not medically necessary. Anthem will advise the attending physician and the hospital of this determination. The hospital will give the member timely notice of such a determination. If a member elects to remain in the hospital after the member has been notified that continued hospitalization is not medically necessary, the Plan will not pay for services after the recommended date of discharge. Anthem will also send written notification of the decision to the member, the attending physician and the hospital. The member will be responsible for all charges incurred after the recommended day of discharge.

If a member or provider disagrees with a concurrent hospital review decision, the member may appeal by following the procedure outlined in the COMPLAINTS, APPEALS AND GRIEVANCES section.

Retrospective Claim Review

Retrospective review of claims consists of reviewing services after the services have been provided to determine whether the services were provided as pre-certified, to evaluate claim charges and to review appropriateness of services billed based on available benefits, medical policy and medical necessity. Anthem may request and review medical records to assist in payment decisions. If it is determined that benefits are not appropriate, the Plan will not pay for such services.

Ongoing Care Needs

Ongoing care is coordinated through services such as utilization management, care management and disease management.
About Your Health Benefits

**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 for treatment is solely between the member and provider regardless of Anthem’s decision made regarding reimbursement.

**Care Management** - Care management is used when illnesses or injuries are so complex that individualized coordination of care is helpful. Examples of such situations include the medical management of a transplant candidate or of a patient with a spinal cord injury. In either of these cases, a care manager may work with the member and/or the member’s 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 and addressed, documented, and resolved in a consistent and timely manner. Care management promotes quality outcomes.

Depending on the level of care management the member may need, a care manager may be assigned to the member. Anthem employs nurses and other medically trained staff with special training in the coordination of care in complex cases. The member may or may not have direct contact with an Anthem care manager. This depends on the availability of a liaison at the facility where the member is admitted. If a care manager is assigned, the care manager’s telephone number is provided to the member so that the member may contact the care manager with any questions. An assigned care manager works with the providers, the member and/or the member’s family to create a plan of care, implement that plan, monitor the use and effectiveness of services, and determine if the member is receiving services in a timely manner and in the most appropriate setting. Anthem may not offer care management to all members of an employer group or to all members with similar conditions.

Anthem’s care management program is tailored to the individual. In certain extraordinary circumstances involving intensive care management, the Plan may, at its sole discretion, provide benefits for alternate care that are not listed as covered services. Anthem will make these decisions on a case-by-case basis. A decision to provide extended benefits or approve alternate care in one case does not obligate Anthem or the employer to provide or pay for the same benefits again to that member or to any other member. The Plan reserves the right, at any time, to alter or cease providing extended benefits or approving alternate care. In such cases, Anthem will notify the member or the member’s representative in writing.

**Disease Management** - Disease management is used to help coordinate care for members who have been diagnosed with specific, persistent or chronic conditions. Anthem may offer disease management programs to members with high-risk pregnancies or who have been diagnosed with chronic illnesses, such as diabetes, heart disease and asthma. Participation in disease management programs is voluntary, and members may choose whether to participate at any time. More complicated conditions may require more intense and/or frequent services.

Disease management strategy includes working with the member to promote self-management and encouraging compliance with the plan of care developed by the member’s 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. Anthem’s disease management programs are based on the best evidence and practices available in peer-reviewed medical literature. Reports are regularly communicated to the member’s provider to promote continuity of care.

Anthem 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 a member does not obligate Anthem to offer other programs to that member or to offer that program to other members.

The participating provider agreements of providing covered services may include financial incentives or risk sharing relationships related to the provision of services or referral to other providers, including network providers and disease management programs. Members may contact the provider or Anthem for questions regarding such incentives or risk sharing relationships.
About Your Health Benefits

Participation in Ongoing Needs Programs
There are several ways for eligible members to become involved in an Anthem care management or disease management program. Anthem can identify members that Anthem believes may benefit from the programs, or physicians may refer their Anthem patients to Us. Members may also contact Anthem directly by calling Anthem’s “Help Line” at (303) 764-7066 or (877) 225-2583.

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

If you are out of state and an Emergency or urgent situation arises, go to the nearest Emergency or Urgent Care Facility. In a non-Emergency situation, you can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Health Benefit ID Card.

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

Care Outside the United States – BlueCard® Worldwide
Before you travel outside the United States, check with your Group or call Member Services at the number on your Health Benefit ID Card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States may be different and We suggest:

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

Call the Service Center in these non-emergency situations:
- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call Us to get approval for benefits at the phone number on your Health Benefit ID Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

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

Claim Filing
- The Hospital will file your claim if the BlueCard Worldwide Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.
About Your Health Benefits

- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to Us.

Claim Forms

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

Subscriber

The following employees are eligible for coverage as a subscriber:

Regular, Special, or Senior Teaching Appointments
Academic Faculty on regular, special or senior teaching appointments of half-time or greater and Administrative Professionals on regular or special appointments of half-time or greater are eligible for benefits as of the date of appointment unless otherwise noted. Faculty Transitional appointments are eligible for the same benefit as Academic Faculty.

Temporary Appointments
Academic Faculty and Administrative Professionals on temporary appointments of half-time or greater are eligible as of the date of appointment unless otherwise noted.

Post-Doctoral Fellows, Veterinary Interns and Clinical Psychology Interns
Post-Doctoral Fellows, Veterinary Interns and Clinical Psychology Interns on appointments of half-time or greater are eligible for benefits, as of the date of appointment.

Dependents

Although individuals may be eligible to participate in a University plan as a “dependent” they may not meet the definition of a “qualified” dependent for federal income tax purposes. If your dependent(s) meets the IRS test as a federal tax dependent he/she is considered a “qualified” dependent. If your dependent(s) does not meet the IRS test, he/she is considered a “nonqualified” dependent. There are tax consequences (imputed income) associated with providing coverage to individuals (domestic partners and children of domestic partners) not meeting the criteria of Section 152 of the Internal Revenue Code which defines a federal tax dependent:

- **Spouse including common-law spouse.** This includes the partner to a civil union, if recognized as a spousal relationship in the state where the Subscriber lives. For information on spousal eligibility please contact the Group.

- **Same or opposite gender domestic partner.** A domestic partner may or may not be your “qualified” federal tax dependent. Enrollment is required using the Affidavit of Domestic Partnership filed by the employee and completion of the criteria as referenced and certified in the affidavit. Criteria on the affidavit includes that you have an exclusive mutual commitment, are each other’s sole domestic partner and intend to remain so indefinitely, are of the same or opposite gender and neither one of you are legally married, are not related by blood, are at least eighteen (18) years old, have been living together for at least 12 months and have joint responsibility for common welfare, living expenses and financial obligations.

- **Newborn child.** A newborn child born to the subscriber or subscriber’s spouse is covered under the subscriber’s benefits for the first 31 days after birth. If the mother of the newborn child is a dependent child of the subscriber, the newborn is not covered.

During the first 31 day-period after birth see the MEMBER BENEFITS section under Maternity and Newborn Care for specific benefits for a newborn child. All services provided during the first 31-days after birth are subject to the cost sharing requirements and the maximum lifetime benefit that are applicable to other sicknesses, diseases and conditions otherwise covered.

To continue benefits beyond the 31-day period after the newborn child’s birth the subscriber must notify the Colorado State University Benefits Unit and complete the enrollment process to add the newborn child as a dependent child to the subscriber’s benefits within 30 days of the birth to ensure that the child’s claims are processed.
• **Adopted child.** An unmarried child (who has not attained 18 years of age) adopted while the subscriber or 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 benefits beyond the 31-day period after the adopted child’s placement the subscriber must notify the Colorado State University Benefits Unit and complete the enrollment process to add the adopted child as a dependent child to the subscriber’s benefits within 30 days of the event to ensure that the child’s claims are processed.

• **Dependent child.** You, your spouse’s, common-law spouse’s or your domestic or civil union partner’s unmarried or married child(ren) including natural children, legally adopted children, foster children placed with you for adoption, stepchildren, children in which legal guardianship has been designated and children defined under a Qualified Medical Child Support Order (QMCSO) (may or may not be your “qualified” federal tax dependent) can be covered under the terms of this benefit booklet. Each child must be an eligible individual defined by the Patient Protection and Affordable Care Act (PPACA) which allows medical coverage through the end of the month in which the child attains the age of 26 regardless of tax dependency status.

• **Disabled dependent child.** Eligible individuals of any age who are dependent on you because of a permanent physical or mental disability to the end of the month in which they turn age 26. Once the disabled dependent reaches age 26, the University requires the dependent to be certified as disabled prior to age 23, a “qualified” federal tax dependent and currently enrolled in the plan to maintain coverage. A completed Mentally or Physically Disabled Dependent Form must be submitted for the disabled dependent to be eligible for benefits. The subscriber and the disabled dependent’s physician must complete this form and submit it to Anthem. A member may call Anthem’s customer service department to obtain a Mentally or Physically Disabled Dependent Form.

**Medicare-Eligible Members**

Before a member becomes age 65, or if a member qualifies for Medicare benefits through other circumstances, the member is responsible for contacting the local Social Security Administration office to establish Medicare eligibility. The member should then contact the member’s employer to discuss coverage options.

If a member qualifies under the provisions of federal law for the working aged, then the member age 65 and older and/or the member’s spouse age 65 or older may continue benefits under this benefit booklet with this coverage primary to any Medicare coverage. Special Medicare Secondary Payer (MSP) rules apply if a member is receiving benefits from Medicare due to a disability or end-stage renal disease. For additional information about Medicare and/or Medicare eligibility rules, contact the local Social Security Administration office.

**Enrollment Process**

In order for eligible subscribers and their eligible dependents to obtain benefits, the subscriber must follow the employer’s enrollment process, which details who is eligible for enrollment. Eligibility for benefits under this benefit booklet begins as of the effective date stated on the health benefit ID card. No services received prior to that date are covered.

**NOTE:** Completion of the enrollment change process does not guarantee member enrollment.

**Enrollment Forms**

The subscriber must complete the Enrollment Change process to add any eligible dependents as members. Additional documentation may be required for special dependent status. Subscribers may obtain the required information from the Colorado State University Benefits Unit.
Membership

Initial Enrollment
Eligible employees may enroll for benefits for themselves and their eligible dependents by completing the enrollment change process within 30 days after the date of eligibility as defined in the Colorado State University Summary Plan Description.

Requirement to Provide a Social Security Number
Members are required to submit their Social Security Number during the enrollment process for compliance with Section III of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). Please see the Colorado State University Summary Plan Description for more information.

Annual Benefits Open Enrollment
Any eligible employee may enroll during the employer’s annual benefits open enrollment period, which is generally held in November, with a subsequent January 1st effective date of the following calendar year. Eligible employees may enroll, cancel, waive, add, drop or change coverage. Eligible employees may also add or delete individual members. The Colorado State University Benefits Unit will provide the dates of the annual benefit open enrollment period.

Newly Eligible Dependent Enrollment
A current subscriber may add a dependent that becomes newly eligible due to a qualifying change of status event. Qualifying change of status events include marriage, birth, and placement for adoption. The Enrollment Change process for the addition of the dependent must be completed within 30 days after the date of the qualifying event. Proof of the qualifying event, e.g. a copy of the marriage certificate or other official documentation, must be submitted to the Colorado State University Benefits Unit. Eligibility for benefits will be effective as outlined in the Colorado State University Summary Plan Description.

When the subscriber or the subscriber’s spouse is required by a court or administrative order for child support, to provide coverage for an eligible dependent, the eligible dependent must be enrolled within 30 days of the issuance of such order. The Colorado State University Benefits Unit must receive a copy of the court or administrative order to complete the Enrollment Change process.

Special Enrollment for Eligible Employees and Eligible Dependents
Special enrollment is available for eligible employees and their eligible dependents that currently are not enrolled in the employer health benefit Plan with Anthem. There are two events when special enrollment may occur, family status change and involuntary loss of coverage.

Family Status Change - Any eligible employee and eligible dependents may enroll when a family status change occurs. Qualifying events for special enrollment due to a family status change include but are not limited to marriage, divorce, birth, placement for adoption or the issuance of a Qualified Medical Child Support Order. Consult with the Colorado State University Benefits Unit for other approved qualifying events and Plan restrictions. Benefits with the Plan will be effective on the date of the qualifying event for birth and adoption benefits and will be effective on the first of the following month for other approved qualifying events as outlined in the Colorado State University Summary Plan Description. Contact the Colorado State University Benefits Unit for additional details. If the employee has not enrolled under the Plan, and the qualifying event is the birth of a child, prenatal, labor and delivery services received prior to or on the date of the qualifying event are not covered since they were received prior to the qualifying event which is the birth of the child. The enrollment process must be completed with the Colorado State University Benefits Unit within 30 days after the date of the qualifying event. Proof of the qualifying event, e.g., copy of marriage certificate or other approved official documentation, must be submitted timely to the Colorado State University Benefits Unit.

Involuntary Loss of Coverage - The involuntary loss of other group health insurance coverage is also a qualifying event for special enrollment for the eligible employee and/or eligible dependents. The involuntary loss of the other coverage must be due to termination of employment, reduction in the number of hours of employment that results in a loss of coverage, involuntary termination of creditable coverage, death of a spouse, legal separation or divorce, or termination of employer contributions toward the coverage. If the employee is approved for special enrollment, the benefits with the Plan will be effective as outlined in the Colorado State University Summary Plan Description. If
Membership

COBRA coverage is originally elected, enrollment may only be requested after exhausting the maximum benefit period of 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 during Colorado State University’s annual benefits open enrollment.

Military Service

Federal and/or state law may entitle an employee to re-enrollment in coverage, upon release from military service. You should contact the Colorado State University Benefits Unit for details. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to employees and their Dependents covered under the Plan before the employee leaves for military service:

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

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

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

How to Change Benefits

If a group provides members with multiple health care options, covered employees may switch benefits for themselves and their covered dependents to another benefit Plan offered by the group during the annual benefits open enrollment period. If a qualifying event occurs, you may be eligible to enroll at times other than the annual benefit open enrollment period. See Special Enrollment For Eligible Employees and Eligible Dependents above for information.

Termination

Active Benefit Termination

Member benefits under this benefit booklet end on the first occurrence of one of the following events:

- On the date the Administrative Services Agreement between the group and Anthem is terminated.
- Upon the subscriber’s death.
- When the required contribution has not been paid, benefits will be terminated at the end of the month in which the member is no longer eligible.
- When the member has committed fraud or intentional misrepresentation of material fact.
- When the member is no longer eligible for benefits under the terms of the Employer Master Contract or Administrative Services Agreement, benefits will be terminated at the end of the month in which the member is no longer eligible.
- When the Colorado State University Benefits Unit gives Anthem notice that the subscriber is no longer eligible for benefits, i.e. employment terminates, the subscriber is in a class of employees which ceases to be
Membership

eligible for coverage, or the plan is terminated. Benefits will be terminated at the end of the month in which the member is no longer eligible. The Plan reserves the right to recoup any benefit payments made for dates of service after the termination date.

See the Continuation of Benefits section for information on how coverage may continue.

Dependent Benefits Termination

to a qualified change in status event, the subscriber must contact the Colorado State University Benefits Unit and complete the enrollment change process within 30 days of the effective date of the change. Contact the Colorado State University Benefits Unit to determine the effective date of termination of coverage, which is generally the last day of the month following the qualifying event date. The Plan reserves the right to recoup any benefit payments made beyond the termination date.

Anthem will credit membership contributions paid in advance on behalf of the terminated dependent unless the Colorado State University Benefits Unit does not receive the Enrollment Change request within 30 days of the effective date of the change or if Anthem has paid any claims on behalf of the terminated dependent in the period for which the credit would otherwise be owed to the employer.

Examples include:

- When the Colorado State University Benefits Unit notifies Anthem in writing to end benefits for a dependent.
- When the dependent child no longer qualifies as a dependent by definition. Such a dependent has the right to select COBRA coverage.
- At the end of the month of a final divorce decree or legal separation for a dependent spouse. Such a dependent has the right to select COBRA coverage.
- At the end of the month when legal custody of a child placed for adoption is terminated.
- If you are a partner to a civil union or other relationship recognized as a spousal relationship in the state where the subscriber resides, on the date such union or relationship is revoked or terminated. Such a Dependent has the right to select COBRA coverage.

See the Continuation of Benefits section for information on how coverage may continue.

Survivor Benefits

Coverage may be continued for surviving eligible individuals based on appointment type as outlined in the Colorado State University’s Summary Plan Description. Contact the Colorado State University Benefits Unit for more information.

What Anthem Will Pay for After Termination

Under the terms of this benefit booklet, Anthem will continue to pay an allowance for covered hospital and physician services directly related to and provided during the member’s inpatient stay for up to 12 months after the member’s coverage ends unless the Administrative Services Agreement with Colorado State University is terminated. Covered services for nervous or mental illness, alcoholism, or drug abuse in a hospital or alcoholism treatment center, however, are limited to a maximum benefit as outlined in the MEMBER BENEFITS section under Mental Health and Substance Abuse Care and Outpatient Therapies. In order to qualify for this benefit extension, the member must meet all three of these conditions:

- The member is an inpatient in a hospital, hospice, or alcoholism treatment center when coverage ends.
- The member inpatient stay remains uninterrupted.
- The member inpatient stay is medically necessary.

Benefits will cease upon any interruption of your inpatient stay or leave of absence from the facility, regardless of the date of discharge.
A transfer from one inpatient facility to another for continuous treatment is not considered to be an interruption of your inpatient stay, unless a period of one day or more elapses between the date of discharge from one facility and the date of admission to another.

Anthem will not pay for any services provided before the members coverage begins, or after the members coverage ends except under the conditions listed above.

Anthem is otherwise liable for payment of covered health care expenses provided only during the period in which coverage under this benefit booklet is in effect. Anthem shall have no liability for other expenses incurred either before the member’s coverage begins, after coverage under this benefit booklet is terminated, or following any amendments which may affect a change in benefit booklet benefits.

Anthem is not responsible for the administration, processing, or payment of any claim for services rendered after the date of termination of Anthem’s contract with Colorado State University, even if such services are otherwise covered under the benefit booklet.

**NOTE:** All other provisions of the benefit booklet shall apply including applicable deductible, copayment, and coinsurance requirements.

**Continuation of Benefits**

**Family and Medical Leave Act**

When an employee is absent from work pursuant to the Family and Medical Leave Act, health benefits remain in-force but the employee may be required to continue paying the employee’s share of the contribution. Members should contact the Colorado State University Benefits Unit for details.

**COBRA Eligibility and Notification**

**COBRA Eligibility** - For employers with 20 or more employees, subscribers and their dependents who lose eligibility with a group are eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Members should contact the Colorado State University Benefits Unit for additional information. Colorado State University has elected to extend COBRA benefits to domestic partners and their “qualifying” dependents as referenced in the following COBRA information. COBRA coverage is available for 18, 29 or 36 months, depending on the qualifying event(s), and only if the application and premium payment requirements of the federal law are met.

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

- When an employee loses coverage due to a reduction in work 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 date of the following qualifying event:

- 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 following individuals 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.
- Spouse and dependent children of a covered employee, when the employee and the spouse are legally separated or divorced.
- 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; it does not extend the COBRA period.

**COBRA Notification** - Unless termination or reduction in hours is the qualifying event, a subscriber, spouse or dependent child must notify the Colorado State University Benefits Unit of eligibility to continue coverage within 60 days after becoming eligible. The employer is responsible for notifying the subscriber, spouse and/or dependent child of how to elect continuation coverage. Once the employer has given notice, Anthem must receive timely notice from the employer of a member’s COBRA election. Anthem must also receive timely payment of appropriate premium charges for a member to be eligible for COBRA.

The COBRA-eligible person has 60 days from the receipt of the employer notification or from the date 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 Election Form*. After electing COBRA coverage, the subscriber must pay the first premium due within 45 days. For more details, the subscriber may contact the Colorado State University Benefits Unit.

**Termination of COBRA**

A member’s continuation coverage terminates when the continuation period is exhausted. The duration of continuation coverage is detailed under the heading *COBRA Eligibility and Notification* in this section.

Continuation coverage may terminate before the expiration of the continuation period if:

- The Administrative Services Agreement between the employer and Anthem is terminated (if the employer selects replacement group coverage, continuation coverage will continue under the new coverage).
- The member fails to pay premium in a timely manner.
- Under COBRA coverage, the member is covered by another group health policy unless the other coverage excludes a condition covered by the continued coverage; in which case, the continuation 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 group health insurance.
- The member becomes entitled to Medicare.
- The member whose COBRA coverage was extended to 29 months is determined under the Social Security Act to no longer be disabled.
- The member submits written notice of voluntary cancellation of coverage.

**Other Coverage Options Besides COBRA Continuation Coverage**

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

This section describes covered services and supplies. Covered services and supplies are only benefits if they are medically necessary or preventive, not otherwise excluded under this benefit booklet as determined by Anthem and obtained in the manner required by this benefit booklet. All services must be standard medical practice where they are received for the illness, injury or condition being treated, and they must be legal in the United States. 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. The member must contact Anthem for certain services to be sure that pre-certification has been obtained by the ordering provider.

Care must be received from a participating provider to be covered at the in-network level, except for emergency care or when pre-certified by Anthem. Services which are not received from a participating provider will be considered out-of-network, unless otherwise specified in this benefit booklet.

Anthem bases its decisions about pre-certification, medical necessity, experimental/investigational and new technology on medical policy developed by Anthem. Anthem will also consider published peer reviewed medical literature, opinions of experts, and the recommendations of nationally recognized public and private organizations, which review the medical effectiveness of health care services and technology.

All covered services are subject to the exclusions listed in this section in addition to those set forth elsewhere in this benefit booklet including those in the GENERAL EXCLUSIONS section. All covered services are subject to the other conditions and limitations of this benefit booklet.

Preventive Care Services
This section describes covered services and exclusions for preventive care.

Children
Benefits are provided for periodic routine exams for members based on guidelines from many sources. Exams include a medical history, complete physical examination, developmental assessment and guidance and routine immunizations. Having the right exams at the right time may help the member avoid serious illness.

Preventive Care Exclusions — The following services, supplies or care are not covered:

- Routine exams related to sports, insurance, school, church or camps.
- Routine care received in the emergency room.

Women
Benefits are provided for periodic routine and non-diagnostic exams (e.g., pelvic exams, breast exams and mammograms) based on guidelines from many sources. Exams and related laboratory and X-ray services shall include a medical history, complete physical examination, medical and preventive guidance, including exercise and nutrition counseling, routine immunizations (including those required for business travel), and colorectal screenings. This section excludes benefits for colonoscopies for preventive reasons; refer to this section under Outpatient Facility Services for coverage of preventive or medical colonoscopies. Having the right exams at the right time may help the member avoid serious illness. Benefits for birth control, infertility and maternity care can be found under Family Planning in this section.

Preventive Care Exclusions — The following services, supplies or care are not covered:

- Routine exams and immunizations related to sports, insurance, for licensing, school, church or camp.
- Employer required screenings or exams for employment.
- Routine care received in the emergency room.

Men
Benefits are provided for periodic routine and non-diagnostic exams (e.g., physical exam, prostate screening) based on guidelines from many sources. Exams and related laboratory and X-ray services shall include a medical history, complete physical examination, medical and preventive guidance, including exercise and nutrition counseling, routine immunizations (including those required for business travel), and colorectal screenings. This section...
Member Benefits

excludes benefits for colonoscopies for preventive reasons; refer this section under Outpatient Facility Services for coverage of preventive or medical colonoscopies. Having the right exams at the right time may help the member avoid serious illness.

Preventive Care Exclusions — The following services, supplies or care are not covered:
- Routine exams and immunizations related to sports, insurance, for licensing, school, church or camp.
- Employer required screenings or exams for employment.
- Routine care received in the emergency room.

Family Planning
This section describes covered services and exclusions for birth control and infertility.

Birth Control
Birth control benefits include family planning counseling and birth control devices provided in a physician’s office. Benefits are provided for:
- Surgical sterilization (e.g., tubal ligation or vasectomy) and related services.
- Injections for birth control purposes.
- Fitting of diaphragm or cervical cap.
- Surgical implantation and removal of a contraceptive device.
- Insertion or removal of an IUD.

Birth Control Exclusions — The following services, supplies or care are not covered:
- Over the counter products for birth control purpose (e.g., sponges, spermicides and condoms).
- Services to reverse voluntarily induced sterility.

Infertility
Benefits are provided only to diagnose the actual cause of infertility. Once the infertility diagnosis has been determined, treatment is limited to those conditions requiring surgical treatment for correction (e.g., opening an obstructed fallopian tube, epididymis, or vas deferens).

Infertility Exclusions — The following services, supplies or care are not covered:
- Any surgeries, treatments, or services when the obstruction is related to the reversal of a surgical sterilization.
- Hormonal manipulation with excess hormones to increase production of mature ova for fertilization.
- Any service, supply or drug used in conjunction with or for the purpose of an artificially induced pregnancy, including Artificial Reproductive Technology (ART) procedures.
- Artificial insemination, including test tube fertilization, drugs for induced ovulation, or other artificial methods of conception. Artificial insemination is the placement of a sperm sample into a female reproductive tract for the purpose of inducing an assisted pregnancy.
- In-vitro (outside the body in an artificial environment) fertilization with husband or other donor sperm and any related services.
- In-vivo (within the living body) fertilization with husband or other donor sperm and any related services.
- Gamete Intrafallopian Transfer (GIFT) or Zygote Intrafallopian Transfer (ZIFT) and any related services.
- Cost of donor sperm or donor eggs.
- Diagnostic tests to determine the effectiveness of a procedure designed to promote fertility or pregnancy.
- Storage costs for sperm or frozen embryos.
Maternity and Newborn Care

This section describes covered services and exclusions for maternity and newborn care. Benefits are provided for maternity and newborn child care, including diagnosis, care during pregnancy and for delivery services. Maternity services include normal vaginal delivery, cesarean section, spontaneous termination of pregnancy prior to full term, therapeutic termination of pregnancy prior to viability, and complications of pregnancy. Benefits are provided for:

- Inpatient, outpatient and physician office services (including prenatal care) for vaginal delivery, cesarean section, and complications of pregnancy.
- Anesthesia services.
- Routine nursery care for a covered newborn including physician services.
- For covered newborns all medically necessary care and treatment of injury and sickness including medically diagnosed congenital defects and birth abnormalities.
- Circumcision of a covered newborn male.
- Laboratory services related to prenatal care, postnatal care or termination of a pregnancy.
- One routine ultrasound per pregnancy. Additional ultrasounds are based on medical necessity, Anthem may request and review medical records to assist in payment decisions when the claim is submitted.
- Covered services from a provider for therapeutic termination of pregnancy regardless of medical necessity, unless applicable law or regulation prohibits employer from providing such coverage (in which case, covered services are provided only to the extent necessary to prevent the death of the mother or unborn child).

Anthem will not limit benefits for a hospital stay in connection with childbirth for the mother and newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. If the delivery occurs between 8 p.m. and 8 a.m., and the 48 or 96 hours have passed, benefits will continue until 8 a.m. the following morning. The mother’s attending physician, after consulting with the mother, may discharge the mother and newborn child earlier if appropriate.

The newborn child must be the child of the subscriber or the subscriber’s spouse to be eligible for benefits. If the mother of the newborn child is a covered dependent child of the subscriber, only the mother’s services are covered benefits. Any services the newborn child receives are not covered benefits.

Maternity and Newborn Care Exclusions — The following services, supplies or care are not covered:

- Services including but not limited to preconception counseling, paternity testing, genetic counseling and testing, or testing for inherited disorders, screening for disorders, discussion of family history or test results to determine the sex or physical characteristics of an unborn child.
- Storage costs for umbilical cord blood.
- Elective termination of pregnancy.

Diabetes Management

This section describes covered services and exclusions for diabetic management. Benefits are provided to members who have insulin dependent diabetes, non-insulin dependent diabetes and elevated blood glucose levels induced by pregnancy or other medical conditions, when medically necessary.

Benefits are provided for diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams. Training and education are covered throughout the member’s disease course when provided by a certified, registered, or licensed health care professional with expertise in diabetes. Insulin pumps and related supplies are covered subject to meeting Anthem’s medical policy criteria. Diabetic supplies and equipment are subject to the annual benefit maximum for medical supplies and equipment as listed on the Summary of Benefits. When diabetic supplies are provided by a pharmacy they are covered under the prescription drug benefits and subject to the prescription copayment and do not apply to the medical equipment and supply benefit maximum.

Diabetes Management Exclusions — The following services, supplies or care are not covered:

- Diabetic supplies and equipment when received from an out-of-network provider.
Physician Office Services

This section describes covered services and exclusions for physician office-based services. In order for the member to receive these benefits, the medical care and services must be received in a physician’s office by a physician or other licensed professional provider.

For preventive care refer to Preventive Care Services in this section. For family planning services, including maternity care, refer to Family Planning in this section. For diabetes treatment refer to Diabetes Management in this section. Refer to this section under Mental Health and Substance Abuse for those services covered by Anthem. To receive office services after hours, refer to Emergency Care and Urgent Care in this section for information. Benefits are provided for medical care, consultations and second opinions to examine, diagnose, and treat an illness or injury when received in a physician’s or other professional provider’s office. A physician may also provide medication management for medical conditions or mental health disorders. Office visits may include administration of injection. Specialty pharmacy drugs used for these injections must be received from Anthem’s specialty pharmacy and listed on Anthem’s Specialty drug list to be covered. Refer to this section under Specialty Pharmacy for more information. Consultations and second opinions may be provided by another physician at the request of the physician or the member. In certain cases, Anthem may request a second opinion.

Benefits are provided for office-based surgery and surgical services, which include anesthesia and supplies. Such surgical fees include local anesthesia and normal post-operative care. Office-based surgical services are subject to pre-certification guidelines. See the Managed Care Features heading in the ABOUT YOUR HEALTH COVERAGE section for information on pre-certification guidelines.

Benefits are provided in a physician’s office for diagnostic services when required to diagnose or monitor a symptom, disease or condition including, but not limited to the following:

- X-ray and other radiology services.
- Laboratory and pathology services.
- Ultrasound services for non-pregnancy related conditions. For pregnancy-related ultrasounds, see the Maternity heading in this section for information.
- Allergy tests.
- Audiometric (hearing) and vision tests required for the diagnosis and/or treatment of an accidental injury or an illness.
- Genetic testing when allowed by Anthem’s medical policy.
- Ultrafast CT scans when pre-certified and allowed by Anthem’s medical policy.

Physician Office Services Exclusions — The following services, supplies or care are not covered:

- Expenses for obtaining medical reports or transfer of files unless such reports or files are requested by Anthem.
- Treatment for hair loss, even if caused by a medical condition, except for alopecia areata.
- Routine foot care such as care for corns, toenails and calluses (except for members with diabetes).
- Telephone or Internet consultations.
- Treatment for sexual dysfunction.
- Genetic counseling.
- Routine hearing exams.
- Separate reimbursement for anesthesia and post-operative care when services are provided by the same physician in the physician’s office.
- Peripheral bone density studies or scans unless they are medically necessary.
Member Benefits

Inpatient Facility Services
This section describes covered services and exclusions for acute inpatient care such as hospital, ancillary and professional services. Acute inpatient services may be obtained from an acute care hospital, long term acute care hospital, rehabilitation hospital, or other covered inpatient facility. All inpatient services are subject to pre-certification or unscheduled admission notification guidelines. See the Managed Care Features heading in the ABOUT YOUR HEALTH COVERAGE section for information on pre-certification guidelines.

Refer to this section under Mental Health and Substance Abuse Care for those services covered by Anthem, including acute medical detoxification. For accident or emergency medical care refer to Emergency Care and Urgent heading under this section. For dental services under this section refer to the heading Dental Related Services for those services covered by Anthem.

Facility Services
A broad spectrum of health care services are provided in the inpatient hospital environment. The following are examples of such covered services:

- Charges for semi-private room (with two or more beds), board, and general nursing services. Benefits are provided for the treatment of medical conditions and rehabilitation care, which is part of an acute care hospital stay.
- Use of operating room, recovery room and related equipment.
- Medical and surgical dressings, supplies, surgical trays, casts and splints when supplied by the facility as part of an inpatient admission.
- Prescribed drugs and medicines administered as part of an inpatient admission.
- A room in a special care unit approved by Anthem. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.
- Inpatient rehabilitation benefits for non-acute hospital admissions for medically necessary care to restore and/or improve lost functions following an injury or illness are limited to 30 days per the member’s benefit year.

Ancillary Services
Numerous medical professionals and para-professionals work together in the inpatient hospital environment to provide comprehensive care to patients. The following list includes, but is not limited to examples of such covered ancillary services:

- Diagnostic services such as laboratory and X-ray tests (e.g., CT scan, MRI).
- Chemotherapy and radiation therapy.
- Dialysis treatment.
- Respiratory therapy.
- Charges for processing, transportation, handling and administration of blood. Any donor credit will be deducted from covered blood expenses.

Professional Services
Professional services are those services provided during the inpatient admission by a physician for surgical and medical care. The following list includes, but is not limited to, examples of such covered professional services:

- Physician services for medical conditions while in the inpatient facility.
- Surgical services, including reconstructive surgery. The surgical fee includes normal post-operative care.
- Anesthesia or anesthesia supplies and services for a covered surgery.
- Intensive medical care for constant attendance and treatment when the member’s condition requires it for a prolonged time.
- Surgical assistants or assistant surgeons as determined by Anthem’s medical policy. Anthem does not pay for a surgical assistant for all surgical procedures. The list of procedures, which allow a surgical assistant or assistant surgeon, is available to the member’s provider.
Member Benefits

- Surgical services for the treatment of morbid obesity, which are subject to meeting the criteria included in Anthem’s medical policy. The hospital performing the morbid obesity surgery must be designated and approved by Anthem to perform specific covered services provided under this benefit.
- Reconstruction of a breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance. Benefits are provided for physical complications for all stages of mastectomy. If a member chooses not to have surgical reconstruction after a mastectomy, Anthem will provide benefits for an external prosthesis.
- For silicone breast implants benefits are provided for the removal of the implant. Implants removed will not be replaced.

Long-Term Acute Care Facility
Long-term acute care facilities are institutions that provide an array of long-term critical care services to members with serious illnesses or injuries. Long-term acute care is provided for members with complex medical needs. These include high-risk pulmonary members with ventilator or tracheotomy needs, medically unstable members, extensive wound care or post-op surgery wound members, and low level closed head injury members. Long-term acute care facilities do not provide care for low intensity member needs. Authorization for admission and for continued stay is required by Anthem. See the Managed Care Features heading in the ABOUT YOUR HEALTH COVERAGE section for information on pre-certification guidelines.

Skilled Nursing Facility
Skilled nursing facilities typically provide uncontrolled, unstable, or chronic condition patients with skilled nursing care, therapies, and protective supervision. Skilled nursing care is provided under medical supervision to carry out nonsurgical treatment of chronic conditions or convalescent stages of acute diseases or injuries. Skilled nursing facility benefits do not include care for members with significant medical needs.

When skilled nursing care is pre-certified by Anthem, benefits are available for up to 100 days per members benefit year or until maximum medical improvement is achieved and no further significant measurable improvement can be anticipated as determined by Anthem. 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. Authorization for admission and for continued stay is required by Anthem. See the Managed Care Features heading in the ABOUT YOUR HEALTH COVERAGE section for information on pre-certification guidelines.

Inpatient Facility Services Exclusions — The following services, supplies or care are not covered:
- Room and board and related services in a nursing home.
- If the member leaves a hospital or other facility against the medical advice of the physician, the charges related to the non-compliance of care.
- Room and board charges from the facility for the discharge day.
- Surgical benefits will not be provided for subsequent procedures to correct further injury or illness resulting from the member’s noncompliance with prescribed medical treatment.
- Procedures that are solely cosmetic in nature. See Anthem’s medical policy at www.anthem.com for information on cosmetic services.
- Custodial and/or maintenance care.
- Any services or care for the treatment of sexual dysfunction.
- Sex change operations, preparation for a sex change operation, or complications arising from a sex change operation.
- Personal comfort and convenience items such as televisions, telephone, guest meals, articles for personal hygiene and other similar services and supplies.
- Surgical services for refractive keratoplasty, including radial keratotomy or lasik, or any procedure to correct visual refractive defect.
- Additional procedures that are routinely performed during the course of the main surgery.
- All surgeries for the treatment of morbid obesity that are not performed at a hospital designated and approved by Anthem.
Outpatient Facility Services

This section describes covered services and exclusions in outpatient facilities. Outpatient facility services may be obtained at facilities such as an acute hospital outpatient department, ambulatory surgery center, radiology center, dialysis center, and outpatient hospital clinics. Some outpatient facility services are subject to pre-certification guidelines. See the Managed Care Features heading in the ABOUT YOUR HEALTH COVERAGE section for information on pre-certification guidelines.

Under this section refer to Mental Health and Substance Abuse Care for those services covered by Anthem. For emergency care refer to the Emergency Care and Urgent Care heading in this section. For dental services refer to Dental Related Services in this section for those services covered by Anthem.

Facility Services

A broad spectrum of health care services are provided in an outpatient facility setting. The following are examples of such covered services:

- Use of operating room, recovery room and related equipment.
- Medical and surgical dressings, supplies, surgical trays, cast and splints when supplied by the facility as part of an outpatient admission.
- Drugs and medicines when provided as part of an outpatient admission. Outpatient Services may include administration of injections. Specialty pharmacy drugs used for these injections must be received from Anthem’s specialty pharmacy and listed on Anthem’s Specialty drug list to be covered. See the Specialty Pharmacy heading in this section for more information.

Ancillary Services

Numerous medical professionals and para-professionals work together to provide comprehensive care to patients in an outpatient facility. The following includes but is not limited to examples of such covered ancillary services:

- Diagnostic services such as laboratory and X-ray tests (e.g., CT scan, MRI).
- Medical and surgical dressings, supplies, surgical trays, or cast and splints when provided in the outpatient department facility.
- Chemotherapy and radiation therapy. Chemotherapy services are available through the outpatient facility. Chemotherapy medications used in conjunction with outpatient therapy may be considered specialty pharmacy drugs and must be received from Anthem’s specialty pharmacy and listed on Anthem’s Specialty drug list. See the Specialty Pharmacy section for more information.
- Dialysis treatment.
- Respiratory therapy.
- Charges for processing, transportation, handling and administration of blood. Any donor credit will be deducted from covered blood expenses.

Professional Services

Professional services are those provided during the outpatient visit by a physician for surgical and medical care for the following:

- Physician services for the medical condition(s) while in the outpatient facility.
- Surgical services. The surgical fee includes normal post-operative care.
- Anesthesia or anesthesia supplies and services for a covered surgery.
- Surgical assistants or assistant surgeons as determined by Anthem’s medical policy. Anthem does not pay for a surgical assistant for all surgical procedures.
- Consultation by another physician when requested by the physician. Staff consultation required by facility rules is excluded.

Outpatient Services Exclusions - The following services, supplies or care are not covered:

- Surgical benefits for subsequent procedures to correct further injury or illness resulting from the member’s noncompliance with prescribed medical treatment.
- Any procedures, services, equipment or supplies provided in connection with cosmetic services.
Member Benefits

- Any services or care for the treatment of sexual dysfunction.
- Sex change operations, preparation for a sex change operation, or complications arising from a sex change operation.
- Personal comfort and convenience items such as televisions, telephone, guest meals, articles for personal hygiene and other similar services and supplies.
- Surgical services for refractive keratoplasty, including radial keratotomy or lasik, or any procedure to correct visual refractive defect.
- Additional procedures that are routinely performed during the course of the main surgery.
- Peripheral bone density studies or scans unless medically necessary.

Emergency Care and Urgent Care

This section describes covered services and exclusions for emergency and urgent care. Emergency care means 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. Urgent care means situations that are not life threatening but require prompt medical attention to prevent serious deterioration in a members health.

Anthem covers emergency services necessary to screen and stabilize a member without pre-certification if a prudent layperson having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life or limb threatening emergency existed. Follow-up care received in an emergency department or urgent care center, including but not limited to, removal of stitches and dressing changes, are not considered emergency care. By choosing an urgent care center when appropriate instead of an emergency room, the member may reduce out-of-pocket expenses.

Emergency Care

Medically necessary emergency care includes emergency accident care and emergency medical care received at a hospital or other facility. Benefits are provided regardless of whether the care is received from a participating provider or non-participating provider. No prior authorization is necessary. A member should call 9-1-1 in the case of a life or limb-threatening emergency.

Whenever a member is admitted to a facility directly from a hospital emergency room, the emergency room copayment will be waived; however, the inpatient hospital copayment will apply to the admission. When a member is admitted to a facility following emergency care, Anthem must be contacted within 5 days of admission or as soon as reasonably possible to receive authorization for continued care after the emergency admission. When Anthem is contacted for authorization for an inpatient stay, the provider and member are notified of the number of days approved for the inpatient stay (e.g., the number of days that are considered medically necessary as determined by Anthem’s medical policy and guidelines).

Once the member is stabilized, ongoing care and treatment is not emergency care. Continuation of care from an out-of-network provider beyond what is needed to evaluate and/or stabilize the member’s condition will be considered out-of-network care and paid subject to the out-of-network payment provisions.

Urgent Care

Benefits are provided for accident or medical care received from an urgent care center or other facility such as a physician’s office. Urgent care is not considered a life or limb-threatening emergency and does not require the use of an emergency room.

Travel outside the country

In an emergency or urgent care situation the member should go to the nearest health care facility. The member will need to pay the bill in full if they are using a provider who is not eligible through the BlueCard program. For more information on the BlueCard program refer to the section entitled ADMINISTRATIVE INFORMATION, under Care Outside the United States BlueCard Worldwide. Use of a credit card is encouraged because the credit card company will automatically transfer the foreign currency into American dollars. When the member returns home, the member should fill out a claim form, which is available by contacting Anthem’s Member Services. The member must submit the claim form along with the receipts to the listed address. The amount submitted must be in American
dollars. Anthem may require medical records for the services received. The member is responsible for providing such medical records. It may be necessary for the member to provide an English translation of the medical records.

**Emergency Care and Urgent Care Exclusions** — The following services, supplies or care are not covered:
- Nonemergency continued care after the member’s condition has stabilized.

**Ambulance and Transportation Services**
This section describes covered services and exclusions for ambulance services. Benefits are provided for local transportation by a vehicle designed, equipped and used only to transport the sick and injured. The vehicle must be operated by trained personnel and licensed as an ambulance to take the member:
- From the members home, scene of an accident or medical emergency to the closest hospital with appropriate emergency facilities.
- Between hospitals for medically necessary transport by ambulance for continuing inpatient or outpatient care.

Ground ambulance is usually the approved method of transportation. Air ambulance is only a benefit when terrain, distance, or the member’s physical condition requires the services of an air ambulance. Anthem will determine whether transport by air ambulance is a benefit on a case-by-case basis. If Anthem determines that ground ambulance could have been used, benefits will be limited to ground ambulance benefits. If the member elects not to receive transport to an emergency facility after an ambulance has been called, the member’s copayment and coinsurance will still apply.

For ground or air ambulance the member pays the appropriate copayment plus coinsurance. The member may reduce the out-of-pocket expense by using a participating provider. Copayments and coinsurance are listed on the Summary of Benefits.

**Ambulance and Transportation Services Exclusions** - The following services, supplies or care are not covered:
- Commercial transport (air or ground), private aviation, or air taxi services.
- Transportation by private automobile, commercial or public transportation or wheelchair ambulance (ambu-cab).
- Ambulance transport if the member could have been transported by automobile, commercial or public transportation without endangering their health or safety.

**Outpatient Therapies**
This section describes covered services and exclusions for physical therapy, speech therapy, occupational therapy, and cardiac rehabilitation.
- Physical therapy may involve a wide variety of evaluation and treatment techniques. Examples include manual therapy, hydrotherapy, heat, or application of physical agents, biomechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, prevent disability following illness, injury, loss of a body part, or congenital defect or birth abnormality. All care must be received from a licensed physical therapist.
- Speech therapy is for the correction of speech impairment resulting from illness, injury, or surgery. Speech therapists are also involved in the medical management of swallowing disorders. All care must be received from a licensed speech therapist. Benefits are provided for speech therapy for a total of 60 treatment sessions per members benefit year for a maximum of three benefit years. Speech therapy benefits are only available for a physician-diagnosed neurological, muscular or structural abnormality involving the organs of speech.
- For a cleft palate or cleft lip condition, speech therapy benefits are provided as indicated above for speech therapy and are subject to the limitations above unless additional visits are medically necessary with no age limits. Such speech therapy visits for member’s from the age of 5 years and older will reduce the number of speech therapy visits allowed.
Member Benefits

- Occupational therapy is the use of constructive activities designed to promote the restoration of the person’s ability to satisfactorily accomplish the ordinary tasks of daily living. All care must be received from a licensed occupational therapist.

**Other Outpatient Therapy Services**

- Cardiac rehabilitation is a program to restore an individual’s functional status after a major cardiac event. Benefits are allowed at a facility for exercise and education under the direct supervision of skilled program personnel in an intensive outpatient rehabilitation program. No more than 36 visits per cardiac event are allowed based on Anthem's medical policy.
- Benefits are allowed for chiropractic services administered by any provider licensed to provide such care, for treatment of an illness of accidental injury. Chiropractic benefits are limited to the office visits with manual manipulation of the spine, X-ray of the spine and certain physical modalities and procedures. Benefits are limited to a maximum of 20 office visits per members benefit year.

**Therapies Exclusions** — The following services, supplies or care are not covered:

- Long-term speech therapy - speech therapy is considered long-term if the physician does not believe significant improvement is possible within 60 sessions.
- Occupational or physical therapy services to maintain function at the level to which it has been restored or when no further significant practical improvement is achieved.
- Non-medically necessary rehabilitation or education classes for cardiac conditions.
- Acupuncture.
- Home programs for on-going conditioning and maintenance.
- Therapies for learning disorders, behavioral or personality disorders, developmental delays, stuttering, voice or rhythm disorders.
- Benefits are not covered for non-specific diagnoses relating to developmental delay and learning-related disorders.
- Therapeutic exercise equipment prescribed for home use such as treadmills and/or weights.
- Convenience items as determined by Anthem.
- The purchase of pools, whirlpools, spas and personal hydrotherapy devices.
- Services related to worker’s compensation injuries.
- Therapies and self-help programs not specifically identified above.
- Recreational, sex, primal scream, sleep, and Z therapies.
- Biofeedback.
- Rebirthing therapy.
- Self-help, stress management and weight loss programs.
- Transactional analysis, encounter groups, and transcendental meditation (TM).
- Sensitivity training, anger management, or assertiveness training.
- Rolfing, pilates, myotherapy or prolotherapy.
- Holistic medicine and other wellness programs.
- Educational programs such as behavior modification or arthritis classes, except as otherwise specifically provided herein.
- Services for sensory integration disorder.
- Occupational therapies for diversional, recreational, or vocational therapies (e.g., hobbies, arts and crafts).

**Autism Spectrum Disorders**

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

- Evaluation and assessment services;
Member Benefits

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

Treatment for Autism Spectrum Disorders must be prescribed or ordered by a Doctor or psychologist, and services must be provided by a Provider covered under this plan and approved to provide those services. However, behavior training, behavior management, or Applied Behavior Analysis services (whether provided directly or as part of Therapeutic Care), must be provided by an Autism Services Provider. Coverage of Autism Spectrum Disorders in this “Benefits/Coverage (What Is Covered)” section is in addition to coverage provided for early intervention and Congenital Defects and Birth Abnormality. Autism services and the Autism Treatment Plan are subject to Utilization Review.

Home Health Care/Home IV therapy

Home Health Care
This section describes covered services and exclusions for home health and home infusion therapy (IV) care. Benefits are provided for services performed by a home health agency engaged in arranging and providing nursing services, home health aide services and other therapeutic related services. Home health services are covered only when such services are necessary as alternatives to hospitalization. Prior hospitalization is not required. Home health services must be rendered pursuant to a physician’s written order, under a plan of care established by the physician in collaboration with a home health agency. Anthem must pre-certify all services and reserves the right to review treatment plans at periodic intervals.

Covered services include the following for up to 60 visits per members benefit year:
- Professional nursing services performed by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N).
- Certified Nurse’s Aide services under the supervision of a Registered Nurse of a qualified therapist with professional nursing services.
- Physical therapy provided by a licensed physical therapist.
- Occupational therapy provided by a licensed occupational therapist or certified occupational therapy assistant.
- Respiratory and inhalation therapy services.
- Speech and hearing therapy and audiology services.
- Medical/social services.
- Medical supplies (including respiratory supplies), durable medical equipment (rental or purchase), oxygen, appliances, prostheses and orthopedic appliances.
- Intravenous medications and other prescription drugs ordinarily not available through a specialty pharmacy or retail pharmacy.
- Nutritional counseling by a nutritionist or dietitian.

Home Infusion/Injection Therapy
Benefits for home infusion therapy (IV therapy) include a combination of nursing, durable medical equipment and pharmaceutical services in the home. Home IV therapy includes, but is not limited to, antibiotic therapy, hydration
therapy and chemotherapy. Intra-muscular, subcutaneous and continuous subcutaneous injections are also covered services. See the heading Food and Nutrition for information on Total Parenteral Nutrition (TPN) and enteral nutrition.

Home Health Care Exclusions — The following services, supplies or care are not covered:

- Services of a mental health social worker. Refer to the heading Mental Health and Substance Abuse Care in this section for those services covered by Anthem.
- Services or supplies for personal comfort or convenience including homemaker services.
- Food services, meals, formulas, and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Religious or spiritual counseling.

Hospice Care

This section describes covered services and exclusions for hospice care. The Plan shall provide benefits for hospice care only with pre-certification by Anthem. Hospice includes medical, physical, social and psychological and spiritual services stressing palliative care for patients.

Covered hospice care can be provided in two environments: 1) the home of the member, or 2) in an inpatient facility.

To be eligible for hospice benefits or inpatient hospice benefits, the patient must have a life expectancy of six months or less, as certified by the attending physician. Hospice care is initially approved for a period of three months. Benefits may continue for up to two additional three-month benefit periods. After the exhaustion of three benefit periods, Anthem will work with the physician and hospice to determine the appropriateness of continuing hospice care. Anthem reserves the right to review treatment plans at periodic intervals.

Hospice care services are covered when such services are provided under active management through a hospice which is responsible for coordinating all hospice care services, regardless of the location or facility in which such services are furnished. Any services provided in connection with an unrelated illness or medical condition will be subject to the benefit booklet provisions that apply to other illness or injuries.

The benefit period for inpatient and outpatient hospice care is limited to three periods of care, each up to three months. Under no circumstances, however, will Anthem provide coverage for more than three benefit periods to any one member.

The following hospice services are covered:

- Hospice day care services provided on a regularly scheduled basis in a day care facility governed by the Hospice Board of Directors to ensure the overall continuum of patient care.
- Hospice home care services provided in the member’s home to meet the member’s physical requirements and/or to accommodate a member’s maintenance or supportive needs for any combination of the following services:
  - Intermittent and 24-hour on-call professional nursing services provided by or under the supervision of a registered nurse (RN);
  - Intermittent and 24-hour on-call social/counseling services;
  - Certified nurse’s aide services under the supervision of a registered nurse or nursing services delegated to other persons;
  - Therapies, including physical, occupational, and speech;
  - Nutritional counseling by a nutritionist or dietitian;
  - Medical social services provided by a qualified individual who possesses at least a baccalaureate degree in social work, psychology, or counseling or the documented equivalent in a combination of education, training, and experience. Such services must be provided at the recommendation of a physician for the purpose of assisting the member or family in dealing with a specified medical condition, and family counseling related to the member’s terminal condition;
Member Benefits

- Inpatient respite care which provides temporary relief for the member’s family from the daily demands of care for the member. Inpatient respite care may be provided only on an intermittent, nonroutine, short-term basis. It may be limited to periods of five days or less.
- 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, shall be paid consistent with any other sickness or illness. Benefits are limited to a separate 30-day period for such care and require prior authorization by the interdisciplinary team except for emergencies admissions. Contact Member Services for information on how to obtain prior authorization.
- Medical supplies, including drugs and biologicals.
- Oxygen and respiratory supplies.
- Prostheses and orthopedic appliances.
- Rental or purchase of durable medical equipment.
- Bereavement support services for the family during the three month period following the death of the Member. This benefit is limited to a $200 total payment.

Hospice Care Exclusions — The following services, supplies or care are not covered:

- Some of these expenses may be covered under benefits otherwise provided by this benefit booklet:
  - Blood, blood plasma, or blood derivatives;
  - Services provided by a hospital;
  - Services related to noncovered conditions and surgeries, as excluded in this benefit booklet;
  - Food services or meals other than dietary counseling;
  - Services or supplies for personal comfort or convenience, including homemaker services, except in crisis periods or in association with respite care.

- Anthem reserves the right to review treatment plans at periodic intervals.

Human Organ and Tissue Transplant Services

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

- Kidney;
- Cornea;
- Any covered services related to a covered transplant procedure received prior to or after the transplant benefit period.

NOTE: The harvest and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

The above covered services are paid as physician office services, inpatient services and outpatient services, depending on where the service is performed. Benefits are excluded for transportation and lodging for those services listed above.

Anthem shall provide benefits for medically necessary human organ and tissue transplant services only when they have pre-certified the services. Benefits include coverage for necessary acquisition procedures, harvest and storage, and including medically necessary preparatory myeloablative therapy. Covered transplant procedures include treatment of breast cancer by high-dose chemotherapy with autologous bone marrow transplantation.

Anthem must designate and approve the hospital who is performing the specific covered services provided under this benefit. Please note, not every designated hospital performs each of the specified covered services. Even if a hospital is an in-network provider for other covered services, it may not be an approved hospital for human organ and tissue transplants.

You can contact the transplant case manager for information for the human organ and tissue transplant covered services available under this benefit booklet.
Anthem and the approved hospital must determine if you are a candidate for any of the covered services specified in this section. Covered transplant procedures are defined as any of the following human organ and tissue transplants or procedures:

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

Anthem may amend the above covered transplant services list to include additional organ or tissue transplants or combinations of transplants based on their medical policy. If you are now eligible, or anticipate receiving eligibility for Medicare benefits, you are solely responsible for contacting Medicare to determine if the transplant will be eligible for Medicare benefits.

Only those human organ and tissue transplants and directly related procedures specified in this section are covered services under this benefit. Benefits will only be provided for covered services and supplies furnished to the transplant recipient starting one day prior to a covered transplant procedure and continuing at the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the in-network provider agreement. At the end of this case rate/global time period, benefits are provided this section under headings of Physician Office Services, Inpatient Services and Outpatient Services, depending on where the service is performed and are not subject to the terms of this Human Organ and Tissue Transplant Services section.

**Hospital Covered Services**

- Room and board for a semi-private room. If a private room is used, this benefit program will only provide benefits for covered services up to the cost of the semi-private room rate unless Anthem determines that a private room is medically necessary.
- Services and supplies furnished by the hospital.
- Prescribed drugs used in the hospital.
- Whole blood, administration of blood, and blood processing.
- Medical and surgical dressings and supplies.
- Care provided in a special care unit, which includes all facilities, equipment, and supportive services necessary to provide an intensive level of care for critically ill patients.
- Use of operating and treatment rooms.
- Diagnostic services, which includes a referral for evaluation.
- Rehabilitative and restorative physical therapy services.

**Surgical Covered Services**

- Surgical covered services in connection with covered human organ and tissue transplants with pre-certification from Anthem (separate payment will not be made for pre-operative and post-operative services or for more than one surgical procedure performed at one operative session).
- Services performed by surgical assistants of such surgery as allowed by Anthem’s medical policy.
- Administration of anesthesia ordered by the physician and rendered by a physician or other provider other than the surgeon or assistant at surgery.

**Medical Covered Services**

- Inpatient and/or outpatient professional services.
- Intensive medical care rendered to a member whose condition requires a physician's constant attendance and treatment for a prolonged period of time.
Member Benefits

- Medical care rendered concurrently with surgery during the hospital stay by a physician other than the operating surgeon for treatment of a medical condition separate from the condition for which the surgery was performed.
- Medical care by two or more physicians rendered concurrently during the hospital stay when the nature or severity of the member’s condition requires the skills of separate physicians.
- Consultation services rendered by another physician at the request of the attending physician, other than staff consultations which are required by hospital rules and regulations.
- Home, office and other outpatient medical care visits for examination and treatment of the member.

Other Services

- Provider requested HLA testing, donor searches and/or a harvest or storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as diagnostic services. If coverage is provided for HLA testing, donor searches, and/or a harvest and storage, it is not an approval for the subsequent requested transplant. A separate medical necessity determination will be made to the transplant procedure.
- Immunosuppressant drugs prescribed for outpatient use in connection with a covered human organ and tissue transplant that are dispensed only by written prescription and that are approved for general use by the Food and Drug Administration, but only if your coverage has a prescription drug benefit.
- Anthem will provide assistance with reasonable and necessary travel expenses as determined by Anthem, 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. Anthem’s 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 Anthem when claims are filed. You may contact Anthem for detailed information. No benefits will be paid until after the transplant services are received. For lodging and ground transportation benefits, Anthem will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

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 Anthem 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 Anthem's member, and the recipient is not covered by Anthem, benefits will not be provided for the donor or recipient expenses.

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

No benefits will be provided for procurement of a donor organ or organ tissue which 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. No benefits will be provided for procurement of a donor organ or organ tissue which has been sold rather than donated.

Only those organ and tissue transplants and directly related procedures specified in this section are covered services under this benefit booklet.

Transplant Benefit Period
Member Benefits

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

Human Organ and Tissue Transplant Exclusions — The following services, supplies or care are not covered:

- Benefits for services performed at any hospital which is not designated or approved by Anthem to provide human organ and tissue transplant services for the organ or tissue being transplanted.
- Benefits for services if the member is not a suitable candidate as determined by the hospital designated and approved by Anthem to provide such services.
- Benefits for services for donor searches or tissue matching, or personal living expenses related to donor searches or tissue matching, for the recipient or donor, or their respective family or friends.
- Any experimental or investigational transplant, treatment, procedure, facility, equipment, drug, device, service, or supply. Any service or supply associated with or provided in follow-up to any of the above.
- 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. Any service or supply associated with or provided in follow-up to any of the above.
- Transplants of organs other than those listed above, including non-human organs.
- Procurement of a donor organ which has been sold rather than donated.
- 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.
- Personal comfort and convenience items such as televisions, telephone, articles for personal hygiene and other similar services and supplies.
- For non-covered transportation and lodging expenses related but not limited to the following:
  - Alcohol, tobacco, other non-food items.
  - Meals.
  - Child care.
  - Mileage within the medical transplant facility city.
  - Rental car, buses, taxis, or shuttle services, except as specifically approved by Us.
  - Frequent Flyer miles.
  - Coupons, vouchers, or travel tickets.
  - Prepayment or deposits.
  - Services for a condition that is not directly related, or a direct result, of the transplant.
  - Telephone calls.
  - Laundry.
  - Postage.
  - Entertainment.
  - Interim visits to a medical care facility while waiting for the actual transplant procedure.
  - Travel expenses for donor companion/caregiver.
  - Return visits for the donor for a treatment of an illness found during the evaluation.

Medical Supplies and Equipment

This section covers services and exclusions for medical supplies, durable medical equipment, oxygen and equipment for its administration, orthopedic and prosthetic devices. Information on diabetic management supplies that are covered by the Plan can be found in this section under the heading Diabetes Management. Supplies are subject to pre-certification guidelines. See the Managed Care Features heading in the ABOUT YOUR HEALTH COVERAGE section for information on pre-certification guidelines.

The supplies, equipment and appliances described in this section are a covered benefit only if supplied by a PPO provider and meets the criteria in Anthem’s medical policy.
Medical Supplies
Disposable items (except prescription drugs) which are required for the treatment of an illness or injury on an inpatient or outpatient basis received from an Anthem PPO provider are covered. Benefits are provided for syringes, needles, surgical dressings, splints and other similar items that treat a medical condition. For supplies received from a pharmacy, refer to the Retail Pharmacy/Mail Order Prescription Drugs heading in this section.

Durable Medical Equipment
Durable medical equipment including such things as crutches, wheelchairs, breathing equipment and hospital beds, are covered if medically necessary and prescribed by a physician. Durable medical equipment generally can withstand repeated use and must serve a medical purpose. The durable medical equipment will be rented or purchased at Anthem’s option. Rental costs must not be more than the purchase price and will be applied to the purchase price. Repair of medical equipment, maintenance, and adjustment because of normal usage is covered if the equipment has been purchased by Anthem or would have been approved by the Plan. Other situations will be reviewed on a case-by-case basis. During repair or maintenance of durable medical equipment, the Plan will provide benefits for replacement rental equipment. Durable medical equipment used as part of an inpatient admission is covered as part of the inpatient hospital admission.

Oxygen and Equipment
Benefits are provided for oxygen and the rental of the equipment needed to administer oxygen (one stationary and one portable unit per member).

Orthopedic Appliances
An orthopedic appliance is a rigid or semi-rigid supportive device that helps to increase the use of a malfunctioning body part or extremity, which limits or stops motion of a weak or poorly functioning body part. An example of an orthopedic appliance is a knee brace. Benefits are provided for the purchase, fitting, needed adjustments and repairs of orthopedic appliances. Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the member.

Prosthetic Devices
A prosthetic device replaces all or part of a missing body part or extremity (leg or arm) to increase the member’s ability to function. Benefits are provided for purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices.

Other Appliances
Benefits for other appliances include:
- Either one set of standard prescription eyeglasses or one set of contact lenses (whichever is appropriate for the medical condition) when necessary to replace human lenses absent at birth or lost through intraocular surgery, ocular injury or for the treatment of keratoconus or aphakia. Replacements are only covered if a physician recommends a change in prescription.
- Breast prostheses and prosthetic bras following a mastectomy.

Medical Supplies and Equipment Exclusions — The following services, supplies or care are not covered:
- Supplies, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass frames, or cryocuff unit). Equipment or appliances that the member requests that include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment when manually operated equipment can be used such as electric wheelchairs or electric scooters).
- Any items available without a prescription such as over-the-counter items and items usually stocked in the home for general use, including but not limited to, bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly.
- Air conditioners, purifiers, humidifiers, dehumidifiers, special lighting or other environmental modifiers, surgical supports and corsets or other articles of clothing, whirlpools, hot tubs, saunas, and biofeedback equipment.
Member Benefits

- Self-help devices that are not medical in nature, regardless of the relief or safety they may provide for a medical condition. These include, but are not limited to, bath accessories, home modifications to accommodate wheelchairs, wheel chair convenience items, wheel chair lifts, or vehicle modifications.
- Dental prosthesis, hair/cranial prosthesis, penile prosthesis or other prosthesis for cosmetic purpose.
- Foot Orthotics (except for members with diabetes), whether functional or otherwise, regardless of the relief they provide.
- Home exercise and therapy equipment.
- Hearing aids and related services and supplies.
- Consumer beds or water beds.
- Repair or replacement needed due to misuse or abuse of any covered medical supply or equipment that is identified in this section.
- Orthopedic shoes not attached to a brace (except for members with diabetes).

**Dental Related Services**

This section covers services and exclusions for accident related dental services, anesthesia for children, inpatient services for dental related services, and cleft palate and cleft lip conditions. Dental services are not covered under this benefit booklet except under the specific circumstances described below. This benefit booklet provides benefits for medical conditions and should not be considered as the member’s dental coverage. All dental services and supplies are subject to pre-certification guidelines. See the Managed Care Features heading in the ABOUT YOUR HEALTH COVERAGE section for information on pre-certification guidelines.

**Accident-Related Dental Services**

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

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

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

**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 provided to a 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.

**Inpatient Admission for Dental Care**

Benefits are provided for inpatient facility services including room and board, but not including charges for the dental services, only if the member has a non-dental-related physical condition, such as bleeding disorders or heart condition that makes the hospitalization medically necessary.

**Cleft Palate and Cleft Lip Conditions**

Benefits are allowed for inpatient care and medical services, including orofacial surgery, surgical management and follow-up care by plastic surgeons and oral surgeons, orthodontics, prosthetic treatment such as obturators, speech
appliances, prosthodontic and surgical reconstruction for the treatment of cleft palate and/or cleft lip. If the member has a dental policy, the dental policy must fully cover orthodontics and dental care subject to the same copayment provisions for the coverage of cleft palate and/or cleft lip as applies to other conditions or procedures covered by the policy.

**Dental Surgery**

Benefits are provided for inpatient hospitalization, physician, dentist or oral surgeon services, (not including, charges for the dental services) if the member is in a hospital for one of the following reasons:

- Excision of exostosis of the jaw (removal of bony growth).
- Surgical correction of accidental injuries to the jaws, cheek, lips, tongue, floor of the mouth, and soft palate (provided the procedure is not done in preparation for dentures or dental prosthesis).
- Treatment of fractures of the facial bones.
- Incision and drainage of cellulitis (infection of the soft tissue).
- Incision of accessory sinuses, salivary glands, or ducts.

Benefit allowances for surgery include payment for visits to the physician or dentist prior to the surgery, administration of local anesthesia for surgery, and follow-up medical care.

**Dental Services Exclusions** — The following services, supplies or care are not covered:

- Restoring the mouth, teeth, or jaws because of injuries resulting from biting, chewing, or an accident or injury principally damaging the teeth.
- Restorations, supplies, or appliances. Examples of such non-covered items include but are not limited to: cosmetic restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metal) that are not medically necessary to stabilize damaged teeth.
- Inpatient or outpatient services required due to the age of the member, medical condition and/or nature of the dental services except as described above.
- Upper or lower jaw augmentation or reductions (orthognathic surgery), even if the condition is due to a genetic, congenital or acquired characteristic, unless orthognathic surgery is required as a result of an accidental injury which occurred after the member’s original membership effective date.
- Artificially implanted devices and bone graft for denture wear.
- Medical or surgical services related to temporomandibular joint therapy or surgery is not covered regardless of medical necessity.
- Administration of anesthesia for dental services, operating and recovery room charges, surgeon services except as allowed above.
- Preventive care and fluoride treatments; dental x-rays, supplies, appliances and all associated expenses; and diagnosis and treatment related to the teeth, jawbones or gums such as extraction (including extraction of impacted wisdom tooth), restoration and replacement of teeth, and services to improve dental clinical outcomes.

**Food and Nutrition**

This section describes covered services and exclusions for nutrition therapy. Benefits for enteral therapy and Total Parenteral Nutrition (TPN) include a combination of nursing, durable medical equipment and pharmaceutical services. Durable medical equipment and supplies are subject to any benefit maximum as listed on the Summary of Benefits. An in-network licensed therapist or home health agency must provide the nutrition services. All services must be pre-certified, see the Managed Care Features heading in the ABOUT YOUR HEALTH COVERAGE section for information on pre-certification guidelines.

**Enteral Therapy and Parenteral Nutrition**

Enteral nutrition is the delivery of nutrients by a tube into the gastrointestinal tract. TPN is the delivery of nutrients through an intravenous line directly into the bloodstream.

Nursing visits to assist with enteral nutrition are covered when medically necessary and not considered custodial care under the home health benefits. These services are frequently provided through a home health agency. More
Member Benefits

Information can be found under the headings of Home Health Care/Home IV Therapy and Hospice Care in this section.

Benefits are provided for medical foods for home use for metabolic disorders. These medical foods can be taken either orally or enterally. A provider must have prescribed the medical foods that are appropriate for inherited enzymatic disorders involved in the metabolism of amino, organic, and fatty acids. Such disorders include: phenylketonuria (foods are covered up to age 21 for men and age 35 for women), maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia and propionic acidemia. This benefit does not include medical foods for members with cystic fibrosis or lactose- or soy- intolerance. All covered medical foods must be obtained through contracted pharmacies and are subject to the pharmacy copayment.

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 members benefit year when pre-certified by Anthem.

Food and Nutrition Exclusions — The following services, supplies or care are not covered:

- Enteral feedings.
- Tube feeding formula except as provided above.
- Weight-loss programs, exercise equipment, exercise classes, health club memberships, personal trainers, prescription or over-the-counter medications for weight loss, or obesity treatment (except medically necessary surgical treatment) even if the extra weight or obesity aggravates another condition.
- Food, meals, formulas, and supplements other than those listed above even if the food, meal, formula or supplement is the sole source of nutrition, other than as provided above.
- Breast feeding education and baby formulas.
- Feeding clinics.

Mental Health and Substance Abuse Care

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

Coverage for mental health care is for a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition. It does not include Autism Spectrum Disorder, which under state law is considered a medical condition. Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) care is covered under this section if the services are given by a mental health Provider.

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

Biologically based mental illnesses and autism are covered under the member’s medical benefits and not subject to the limitations of the mental health benefit. They are covered the same as any other physical illness, and described in the appropriate sections of the benefit booklet depending upon the type of care received. Biologically based mental illnesses are schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder, and panic disorder.

Mental health conditions described in this section are for non-biologically based mental health conditions identified as a mental disorder 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. Services for Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) are covered as mental health conditions if provided by a licensed mental health provider. Benefits are then paid under the mental health benefit. Substance abuse is not
considered a mental health condition for the purpose of this benefit; services for substance abuse, which are limited to detoxification and rehabilitation, are described below.

Substance abuse conditions described in this section are for acute medical detoxification and for substance abuse rehabilitation. Substance abuse 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 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 substance abuse conditions on an inpatient or outpatient basis for treatment that will assist the member to live without abusing drugs or alcohol.

Benefits are provided for medically necessary inpatient care, outpatient care, and provider office services for the diagnosis, crisis intervention, and treatment of mental health conditions and substance abuse conditions. Inpatient services must be provided by a licensed hospital, psychiatric hospital, alcoholism treatment center, or residential treatment center. Outpatient facility and provider office services must be performed by a physician, licensed clinical psychologist or other professional provider who is properly licensed or certified to practice psychotherapy.

**Inpatient Services**

Inpatient Services to treat mental health conditions are subject to medical policy and medical necessity. Treatment for inpatient mental health and/or alcoholism conditions and Provider visits received during a covered admission are covered.

Covered services include but are not limited to:

- Inpatient semi-private room and ancillary services including laboratory and X-ray services.
- Individual psychotherapy.
- Group psychotherapy.
- Psychological testing.
- Family counseling with family members to assist in the member’s diagnosis and treatment.
- Medication management.
- Provider visits during a covered admission.

**Partial Hospitalization Services**

Partial hospitalization services are covered for mental health conditions and alcoholism. The same services covered for inpatient services are also covered for partial hospitalization. One inpatient day is defined as an admission to a facility for more than 12 hours of treatment. One-partial treatment day is defined as no less than 3 and no more than 12 hours of therapy per day. Partial day treatment is covered only when the member receives care through a day treatment program.

**Outpatient Services**

The same services covered as inpatient services are also covered for outpatient and intensive outpatient program services (except room, board, general nursing and ancillary services) if such services are for less than 3 hours per day for mental health and substance abuse conditions. Benefits for outpatient laboratory and radiology services for the diagnosis and treatment of mental health conditions are provided at the same coinsurance level as other mental health conditions.

**Mental Health and Substance Abuse Exclusions** — The following services, supplies or care are not covered:

- Services or care provided or billed by a school, halfway house, custodial care facility for the developmentally disabled, residential programs for drug and alcohol, or outward bound programs, even if psychotherapy is included.
- Residential programs for drug and alcohol rehabilitation, which are not in the Anthem network.
- Partial hospitalization for substance abuse care.
- Private room expenses.
- Biofeedback.
Member Benefits

- Psychoanalysis or psychotherapy that a member may use as credit toward earning a degree or furthering his/her education.
- Hypnotherapy.
- Religious, marital and social counseling.
- The cost of any damages to a treatment facility caused by the member.
- Recreational, sex, primal scream, sleep, and Z therapies.
- Self-help, stress management, and weight-loss programs.
- Transactional analysis, encounter groups, and transcendental meditation.
- Sensitivity training, anger management, and assertiveness training.
- Behavior modification programs.
- Rebirthing therapy.

Prescription Drugs Administered by a Medical Provider

Benefits are covered for Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient facility. This includes drugs for infusion therapy, chemotherapy, specialty drugs, blood products, and office-based injectable that must be administered by a Provider. This section applies when your Provider orders the drug and administers it to you. Benefits for drugs that you can inject or get at a Pharmacy (i.e., self-administered injectable drugs) are not covered under this section. Benefits for those drugs are described in the Specialty Pharmacy and Retail Pharmacy/Mail Order Prescription Drugs sections.

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

Important Details About Prescription Drug Coverage

Your plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked for more details before We can decide if the drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics (P&T) Process.

Pre-certification

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

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

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

Step Therapy

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

Therapeutic Substitution

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

Specialty Pharmacy

The benefits of this section include specialty pharmacy drugs listed on the Specialty drug list. Specialty pharmacy drugs are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at a retail pharmacy. Benefits are only provided when you receive services from a specialty pharmacy as determined by Anthem for those specialty pharmacy drugs included on the Specialty drug list.

Specialty pharmacy services are for specialty pharmacy drugs and do not include services received from a retail pharmacy, in the hospital as an inpatient, or if a medical supply, durable medical equipment or appliance. Refer to this section under the headings of Inpatient Services and Medical Supplies, Durable Medical Equipment, and Appliances for services covered by the benefit booklet. This section describes Anthem’s outpatient pharmacy benefits for specialty pharmacy drugs obtained through a specialty pharmacy which will be used in place of receiving the service from your physician’s office, outpatient facility, home health care agency, retail pharmacy or other specialty pharmacy unless you qualify for an exception.

The outpatient specialty pharmacy benefits available under this benefit booklet are provided by the Pharmacy Benefits Manager (PBM). The PBM is a full service specialty pharmacy which ships medications to you by overnight mail or common carrier for up to a 34-day supply (you cannot pick up your medication from the PBM). The PBM is not a retail pharmacy or a mail order service.

You may review the current specialty pharmacy drug list on Anthem’s website at www.anthem.com. You may also request a copy of the specialty pharmacy drug list by calling our Member Services department. The Anthem Specialty drug list is subject to periodic review and amendment. Inclusion of a drug or related item on the Specialty drug list is not a guarantee of coverage.

Your copayment amount is based upon the above and which tier the specialty pharmacy drug fall under as follows:

**Tier-1** — means a drug that has the lowest copayment. This tier will contain low cost or preferred medications. This tier may include generic drugs, single source drugs and multi-source brand drugs.

**Tier-2** — means a drug that has a higher copayment than those in tier 1. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic drugs, single source brand drugs and multi-source brand drugs.

**Tier-3** — means a drug that has a higher copayment than those on tier 2. This tier may contain non-preferred medications which are generally higher in cost. This tier may include generic drugs, single source brand drugs, and multi-source brand drugs.

Prescription drugs will always be dispensed as ordered by your provider and by applicable State Pharmacy Regulations. You may request, or your provider may order, a brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and brand-name drug, in addition to your tier 1 copayment. 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.

Anthem uses a variety of administrative processes and tools, such as pre-certification for health care services to help determine the most appropriate and cost-effective use compared to alternative interventions for the health care services available to its members. Certain specialty pharmacy drugs may require pre-certification. At the time you fill a prescription, you will be informed of the pre-certification requirement. For a list of current drugs requiring pre-certification, contact Anthem’s Member Services department, or review the list on the website at www.anthem.com.
Member Benefits

Outpatient specialty pharmacy benefits include a therapeutic drug substitution program approved by Anthem and managed by the PBM. This is a voluntary program designed to inform you and physicians about alternatives to specialty pharmacy drugs. The PBM may contact you and the prescribing physician to make you aware of the substitution options. Therapeutic substitutions may also be initiated at the time the specialty pharmacy drug is dispensed. Only you and the physician together can determine whether the therapeutic substitute is appropriate for you.

You or your physician may order your specialty pharmacy drug from the PBM by calling 1-800-870-6419. A dedicated care coordinator will guide you or your physician through the process up to and including actual delivery of your specialty pharmacy drug to you or your physician. When you order a specialty pharmacy drug for home, physician office or outpatient facility use, you will need to pay the appropriate separate deductible or coinsurance up to the separate out-of-pocket annual maximum for each specialty pharmacy drug by check, money order, credit card or debit card and provide all necessary information. For subsequent refills you will be contacted by your care coordinator.

Exception Process for Specialty Pharmacy Drugs

If you or your Provider believe that you should not be required to get your specialty pharmacy drugs from a specialty pharmacy, you must follow the exception process which is available from Anthem’s Member Services department or at www.anthem.com.

Specialty Pharmacy Drugs and Medicines Exclusions — The following services, supplies or care are not covered:

- When benefits are provided under the specialty pharmacy benefits they will not be provided under the Prescription Drugs Administered by a Medical Provider or Retail Pharmacy/Mail Order Prescription Drug section of this benefit booklet.
- Outpatient prescription drugs or medications that are specialty pharmacy drugs received from a retail pharmacy. You will pay the full cost of the specialty pharmacy drug when received from a retail pharmacy since those services should have been received from a specialty pharmacy.

Retail Pharmacy/Mail Order Prescription Drugs

This section describes covered services and exclusions for outpatient pharmacy prescription drugs and medications. Anthem allows inpatient pharmacy benefits for prescription drugs when billed by a hospital or other facility for a covered inpatient stay. Refer to the Inpatient Facility Services heading in this section for information on inpatient care. For special foods and formulas for metabolic and nutritional needs refer to the Food and Nutrition heading for information. Home intravenous (I.V.) therapy is also a benefit as stated under the heading Home Health care/Home IV Therapy.

The outpatient pharmacy benefits available under this benefit booklet are managed by the Pharmacy Benefits Manager (PBM). The PBM offers a nationwide network of retail pharmacies, a mail service pharmacy and clinical services that provide formulary management.

The PBM, in consultation with Anthem, also promotes and enforces the appropriate use of medications by reviewing for improper dosage, potential drug-to-drug interactions or drug-pregnancy interactions.

The member may review the current formulary on Anthem’s website at www.anthem.com, under prescription benefits. The member may also request a copy of the formulary by calling Our Member Services department at the number listed on the bottom of this page. The formulary is subject to periodic review and amendment. Inclusion of a drug or related item on the formulary is not a guarantee of benefits.

For certain prescription drugs, the prescribing physician may be asked to provide additional information before Anthem will determine medical necessity. Anthem may, at its sole discretion, establish quantity limits for specific prescription drugs. Covered services will be limited based on medical necessity, quantity limits established by Anthem, or utilization guidelines. The member’s copayment amount depends on whether a formulary or non-formulary drug is obtained and is listed on the Summary of Benefits.

Certain prescription drugs (or the prescribed quantity of a particular drug) may require pre-certification. Pre-certification helps promote appropriate utilization and enforcement of guidelines for prescription drug benefit.
coverage. At the time the member fills a prescription, the network pharmacist is informed of the pre-certification requirement through the pharmacy’s computer system, and the pharmacist is instructed to contact the PBM. The PBM uses pre-approved criteria reviewed and adopted by Anthem. The PBM may contact the prescribing physician if additional information is required to determine whether pre-certification should be granted. For a list of current drugs requiring pre-certification, contact an Anthem Member Services representative at the number listed on the bottom of the page, or review on Anthem’s website at www.anthem.com. If pre-certification is denied, the member may appeal the decision by following the instructions found in the CLAIMS, GRIEVANCES AND APPEALS section.

The provider or network pharmacist can check with the PBM to verify formulary drugs, any quantity limits, pre-certification requirements, or appropriate tier recognized under the benefit booklet.

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

Outpatient pharmacy benefits received from a network retail pharmacy are limited to:

- Prescription drugs, including self-administered injectable drugs. These are Prescription drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the Prescription Drugs Administered by a Medical Provider benefit in this section
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive drugs, contraceptive devices and contraceptive injections from a pharmacy.
- Certain supplies, equipment and appliances (such as those for diabetes and asthma). The member may contact Anthem to determine approved supplies covered through a pharmacy.
- Smoking cessation prescription drugs.

If certain supplies, equipment and appliances are not obtained by mail service or from a network pharmacy, they may be covered medical equipment or supplies under the other sections of this benefit booklet. See the Medical Supplies and Equipment section for information.

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 the member’s copayment, amount or the retail price charged for the prescription by the pharmacy or mail order service that fills the prescription. The copayment will not be reduced by any discounts, rebates or other funds received by Anthem or the PBM from drug manufactures, or similar vendors. Anthem will make no payment for any covered drug or supply unless Anthem’s negotiated rate exceeds any applicable copayment for which the member is responsible.

The member is limited to a 34-day supply of a prescription drug if obtained at a network pharmacy or up to a 90-day supply if received through mail order. When medically necessary, a one-month vacation override is available if the member is traveling out of the Anthem service area.

The member must obtain covered prescription drugs and supplies from a network pharmacy. All prescription drugs must be legend drugs to be eligible for benefits. The copayment amount is based upon whether the member obtains a tier 1, tier 2, or tier 3 prescription drug and whether formulary or non-formulary prescription legend drugs are dispensed. Members have three tiers of copayments for covered prescription drugs including injectable drugs as follows:

**Tier-1** — means a drug that has the lowest copayment. This tier will contain low cost or preferred medications. This tier may include generic drugs, single source drugs and multi-source brand drugs.

**Tier-2** — means a drug that has a higher copayment than those in tier 1. This tier will contain preferred medications that generally are moderate in cost. This tier may include generic drugs, single source brand drugs and multi-source drugs.
Member Benefits

Tier-3 — means a drug that has a higher copayment than those on tier 2. This tier may contain non-preferred medications which are generally higher in cost. This tier may include generic drugs, single source brand drugs, and multi-source brand drugs.

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 1 copayment. 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.

Copayment amounts for prescription drugs, other than those which are flat dollar amounts, are calculated based upon the applicable in-network pharmacy contracted prices for covered prescription drugs and supplies. Copayment amounts for prescription drugs, do not apply towards the annual out-of-pocket limit.

How to Obtain Outpatient Prescription Drug Benefits

How the member obtains benefits depends on whether the member uses a retail or mail service pharmacy.

Network Pharmacy — The member presents the written prescription order from the physician and the member identification card to the pharmacist at a network pharmacy. The pharmacy will file the claim for the member. The member is charged at the point of purchase for applicable copayment amounts.

If the member does not present the health benefit ID card at a network pharmacy, the member will have to pay the full cost of the prescription. If the member does pay the full charge, the member should ask the pharmacist for an itemized receipt and submit it to Anthem with a written request for reimbursement. The member will be reimbursed based on the charge for the covered drug, less the applicable tier 1, tier 2, or tier 3 copayment. Prescription drugs dispensed in excess of a 34-day supply are not reimbursable.

Mail Service — Mail service offers a convenient means of obtaining maintenance prescription drugs by mail if the member takes prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed pharmacy mail service that has entered into a reimbursement agreement and are sent directly to the member’s home. Maintenance prescription drugs are those used on a continuing basis for the treatment of a chronic illness such as heart disease, high blood pressure, arthritis or diabetes. The member must complete the Order and Patient Profile Form, which is available from Anthem Member Services or on Anthem’s website at www.anthem.com. The member will need to complete the patient profile information only once. The member may mail written prescriptions from the physician, or have the physician fax the prescription to the PBM’s mail service address. The member physician may also phone in the prescription to the PBM’s mail service. The member will need to submit the applicable copayment amounts to the PBM’s mail service when the member requests a prescription or refill. The member’s copayment is the same as for prescriptions filled at a network pharmacy for a 34-day supply, and two times that for a supply greater than 34-days. Class II prescription drugs (e.g., narcotics) will only be dispensed in a 34-day supply.

Retail Pharmacy/Mail Order Prescription Drugs and Medicines Exclusions — The following services, supplies or care are not covered:

- Prescription drugs and supplies received from a non-network pharmacy.
- Non-legend prescription drugs.
- Drugs prescribed for weight control or appetite suppression.
- Medication or preparations used for cosmetic purposes to promote hair growth, prevent hair growth, or medicated cosmetics. These include, but are not limited, to Rogaine®, Viniqa®, and Tretinoin (sold under such brand names as Retin-A®).
- Drugs not approved by the FDA.
- Any medications used to treat infertility.
- Special formula, food, or food supplements (unless for metabolic disorders, see the heading of Food and Nutrition in this section for benefits), vitamins, or minerals, except for legend drug prenatal vitamins.
- Delivery charges for prescriptions.
Member Benefits

- Charges for the administration of any drug unless dispensed in the physician’s office or through home health care.
- Drugs which are provided as samples to the provider.
- Antibacterial soap/detergent, toothpaste/gel, shampoo, or mouthwash/rinse.
- Hypodermic needles, syringes, or similar devices, except when used for administration of a covered drug when prescribed in accordance with the terms of this section.
- Therapeutic devices or appliances, including support garments and other non-medicinal supplies (regardless of intended use).
- Nonprescription and over-the-counter drugs, including herbal or homeopathic preparations, and Prescription Drugs that have a clinically equivalent alternative, even if written as a prescription. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) except for injectable insulin.
- Prescription drugs, which are dispensed in quantities, which exceed the applicable limits, established by the Plan.
- Refills in excess of the quantity prescribed by the provider, or refilled more than one year from the date prescribed.
- Prescription Drugs intended for the treatment of sexual dysfunction or inadequacies, regardless of origin or cause (including drugs for the treatment of erectile dysfunction such as Viagra®).
- Prescription Drugs dispensed for the purpose of international travel.
- Replacement of lost or stolen prescription drugs.

Private-Duty Nursing Services
Anthem will allow inpatient benefits for private-duty nursing services when the member’s condition ordinarily requires that they are placed in an intensive or coronary care unit, but the hospital does not have such facilities. Outpatient benefits are allowed in the member’s home or other outpatient location. Private-duty nursing benefits are limited to a maximum combined inpatient and outpatient payment of $10,000 per benefit year.

Vision Exam
Anthem will allow outpatient benefits for one routine eye exam or routine refractive eye exam once per member benefit year when performed by an ophthalmologist or optometrist.

Vision Exam Exclusions — The following services, supplies or care are not covered:
- Lenses, frames or contact lenses. Benefits for medically necessary eyeglasses or contact lenses see the heading of Medical Supplies and Equipment in this section for information.
- Special procedures such as orthoptics, vision training or vision aids.
General Exclusions

These general exclusions apply to all benefits described in this benefit booklet, unless otherwise stated in this certificate or required by law. Coverage for benefits shall meet or exceed those required by applicable insurance law, which may change from time to time.

This self-funded health benefit Plan provides benefits for specific services described in this benefit booklet and not listed as an exclusion. The following list of exclusions is not a complete list of all services, supplies, conditions or situations that are not covered services. In addition to these general exclusions, specific limitations, conditions and exclusions apply to specific covered services, which can be found in the MEMBER BENEFITS section and elsewhere in this benefit booklet.

If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem will determine if services and supplies are medically necessary for the purpose of payment.

The Plan will not allow benefits for any of the following services, supplies, situations, or related expenses:

**Acupuncture** — The benefit Plan does not cover services related to acupuncture, whether for medical or anesthesia purposes.

**Alternative or complementary medicines** — This benefit Plan does not cover alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aromatherapy, massage therapy, reiki therapy, herbal medicine, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), clonics or iridology.

**Artificial conception** — All services related to artificial conception are not covered except as provided under the heading Family Planning found in the MEMBER BENEFITS section.

**Auto accident injuries** — All services related to an auto accidents will be coordinated with the benefits of a complying automobile insurance policy as provided under the heading Automobile Insurance Provisions found in the ADMINISTRATIVE INFORMATION section.

**Before effective date** — This benefit Plan does not cover any service received before the member’s effective date of benefits.

**Biofeedback** — This benefit Plan does not cover biofeedback and related services.

**Chelating agents** — This benefit Plan does not cover any service, supply, or treatment for which a chelating agent is used, except for providing treatment for heavy metal poisoning.

**Clinical research** — This benefit Plan does not cover any services or supplies provided as part of clinical research unless allowed by Anthem’s medical policy. A signed consent form for human research subjects will be considered proof that a member is involved in a clinical research program.

**Complications of non-covered services** — This benefit Plan does not cover complications arising from non-covered services and supplies. Examples of non-covered services include but are not limited to, cosmetic surgery, sex-change operations and procedures, which are determined to be experimental/investigational.

**Convalescent care** — Except as otherwise specifically provided, this benefit Plan does not cover convalescent care from a period of illness, injury, surgery, unless normally received for a specific condition, as determined by Anthem’s medical policy. Convalescent care includes the physician’s or facilities services.

**Convenience/luxury/deluxe-services/or equipment** — This benefit Plan does not cover services and supplies used primarily for the member’s personal comfort or convenience. Such services and supplies includes, but are not limited to, guest trays, beauty or barber shop services, gift shop purchases, telephone charges, television, admission kits, personal laundry services, and hot and/or cold packs.

This benefit Plan does not cover supplies, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass frames, or cryocuff unit). Equipment or appliances the member requests that include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment when manually operated equipment can be used such as electric wheelchairs or electric scooters) are not covered.
General Exclusions

Cosmetic services — any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve the member’s appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of skin or to change the size, shape or appearance of facial or body features (such as nose, eyes, ears, cheeks, chin, chest or breasts) except where coverage of such procedures, services or supplies are specifically required by applicable law.

Court ordered services — This benefit Plan does not cover services that are required under court order, parole or probation unless those services would otherwise be covered under this benefit booklet.

Custodial care — This benefit Plan does not cover care primarily for the purpose of assisting the member in the activities of daily living or in meeting personal rather than medical needs, and which is not a specific treatment for an illness or injury. Custodial care cannot be expected to substantially improve a medical condition, and has minimal therapeutic value. Care can be custodial even if it is recommended or performed by a professional and whether or not it is performed in a facility (e.g., hospital or skilled nursing facility) or at home. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing.
- Transfer or positioning in bed.
- Administration of medication that is usually self-injected.
- Meal preparation.
- Assistance with feeding.
- Oral hygiene.
- Routine skin and nail care.
- Suctioning.
- Toileting.
- Supervision of medical equipment or its use.

Dental services — Dental services are not covered except as provided in MEMBER BENEFITS under Dental Related Service.

Discharge — All inpatient services received after the date Anthem, using managed care guidelines, determines discharge is appropriate.

Discharge against medical advice — This benefit Plan does not cover hospital services if the member leaves a hospital or other facility against the medical advice of the physician.

Discharge day expense — All room and board services related to a discharge day are not covered except as provided in the MEMBER BENEFITS section.

Domiciliary care — This benefit Plan does not cover care provided in a residential, non-treatment institution, halfway house or school.

Duplicate (double) coverage — This benefit Plan does not cover services and supplies already covered by other valid coverage, see the heading Duplicate Coverage and Coordination of Benefits in the ADMINISTRATIVE INFORMATION section.

Experimental/Investigative procedures — Any treatment, procedure, drug or device that has not been found by Anthem to meet the eligible-for-coverage criteria. The determination that a service is not considered eligible-for-coverage or is experimental/investigational can be made by Anthem either before or after the service is rendered if the service has not been pre-certified. Anthem does not cover treatment or procedures which are experimental/investigational, or which are not proven to be effective as determined by Anthem's medical policy or, if no medical policy is available, as determined by appropriate medical/surgical authorities selected by Anthem.

Genetic testing/counseling — This benefit Plan does not cover services including, but not limited to, preconception, paternity testing, court-ordered genetic counseling and testing, testing for inherited disorders, discussion of family history or testing to determine the sex or physical characteristics of an unborn child. Genetic tests to evaluate risks of disorders for certain conditions may be covered based on medical policy, review and criteria and after appropriate pre-certification.
General Exclusions

**Government operated facility** — This benefit Plan does not cover services and supplies for all military service connected disabilities furnished by a military medical facility operated by, for, or at the expense of federal, state, or local governments or their agencies, including a veterans administration facility, unless Anthem authorizes payment in writing before the services are performed.

**Hair loss** — This benefit Plan does not cover treatment for hair loss, drugs, wigs, hair pieces, artificial hairpieces, hair or cranial prosthesis, hair transplants or implants even if there is a physician prescription and a medical reason for the hair loss.

**Hearing** — This benefit Plan does not cover hearing aids or routine hearing tests.

**Hypnosis** — This benefit Plan does not cover services related to hypnosis, whether for medical or anesthesia purposes.

**Illegal conduct** — This benefit Plan does not cover services or supplies for illness or injuries resulting wholly or partially from conduct attributable to the member which may be deemed a crime or other violation of law.

**Intractable pain or chronic pain** — This benefit Plan does not cover services or supplies for the treatment of intractable pain and/or chronic pain. Chronic pain is pain of continuous and long-standing duration where the cause cannot be removed.

**Learning deficiency and/or behavioral problem therapies** — This benefit Plan does not cover services or supplies (including but not limited to speech therapy) for dysfunctions that are self-correction 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).

**Maintenance therapy** — This benefit Plan does not cover any treatment that does not significantly enhance or increase the members function or productivity, or care provided after the member has reached his/her maximum medical improvement, except as provided in the MEMBER BENEFITS section.

**Medical necessity** — This benefit Plan does not cover expenses for services and supplies that are not medically necessary. Services may be denied before or after payment unless pre-certification has been received. Anthem’s decision as to whether a service or supply is medically necessary is based on medical policy, and peer reviewed medical literature as to what is “approved and generally accepted medical or surgical practice.” The fact that a provider may prescribe, order, recommend, or approve a service does not, of itself, make it medically necessary or an allowable expense, even though it is not specifically listed as an exclusion.

**Missed appointments** — This benefit Plan does not cover charges for the member’s failure to keep scheduled appointments. The member is solely responsible for such charges.

**Neuropsychiatric testing** — This benefit Plan does not cover neuropsychiatric testing unless allowed by Anthem’s medical policy.

**Non-covered providers of service** — This benefit Plan does not cover services and supplies prescribed or administered by a provider or other person, or facility not specifically listed as covered in this benefit booklet. These non-covered providers or facilities include, but are not limited to:

- 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.
- School infirmary.
- Halfway house.
- Massage therapist.
- Nursing home.
- Residential institution or halfway house (facility where the primary services are room and board and constant supervision or a structured daily routine for a person who is impaired but whose condition does not require acute care hospitalization).
- Dental or medical services sponsored by or for an employer, mutual benefit association, labor union, trustee, or any similar person or group.
General Exclusions

- Services provided by the member upon themselves, by a family member, or by a person who ordinarily resides in the member’s household.

**Non-medical expenses** — This benefit Plan does not cover non-medical expenses, including but not limited to:

- Adoption expenses.
- For any services or supplies provided to a person not covered under the benefit booklet in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- Educational classes and supplies not provided by the member’s provider unless specifically allowed as a benefit under this benefit booklet.
- Vocational training services and supplies.
- Mailing and/or shipping and handling expenses.
- Interest expenses and delinquent payment fees.
- Modifications to home, vehicle, or workplace regardless of medical condition or disability.
- Membership fees for spas, health clubs, personal trainers, or other such facilities even if medically recommended, regardless of any therapeutic value.
- Personal convenience items such as air conditioners, humidifiers, or exercise equipment.
- Personal services such as haircuts, shampoos, guest meals, and radio or televisions.
- Voice synthesizers or other communication devices, except as specifically allowed by Anthem’s medical policy.

**Non-participating provider services** — Services received from non-participating providers for the following services are not covered:

- Adult preventive services.
- Home health care.
- Mental health care.
- Alcoholism care.
- Substance abuse care.
- Organ transplants.
- Durable medical equipment including oxygen and the equipment to administer it.
- Vision care.
- Chiropractic care.

**Nutritional and/or dietary supplements** — This benefit Plan does not cover nutritional and/or dietary supplements unless otherwise specified in this benefit 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.

**Orthognathic surgery** — This benefit Plan does not cover upper or lower jaw augmentation or reductions (orthognathic surgery) even if the condition is due to a genetic congenital or acquired characteristic.

**Over-the-counter products** — This benefit Plan does not cover any items available without a prescription such as over-the-counter items and items usually stocked in the home for general use including but not limited to bandages, gauze, tape, cotton swabs, dressing, thermometers, heating pads, and petroleum jelly. This benefit Plan does not cover laboratory test kits for home use. These include, but are not limited to, home pregnancy tests and home HIV tests.

**Post-termination benefits** — Benefits are not provided for care received after benefits are terminated except as provided in the MEMBERSHIP section.

**Pre-existing conditions** — A pre-existing condition is any condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received 90 days prior to the individual’s effective date with a CSU plan. However, the plan no longer applies a pre-existing condition exclusion for covered services.
General Exclusions

**Private room expenses** — All services related to a private room are not covered except as provided in the MEMBER BENEFITS section.

**Professional courtesy** – This benefit Plan does not cover charges for services and supplies when the member has received a professional or courtesy discount from a provider. This benefit Plan does not cover any services where the member’s portion of the payment is waived due to professional courtesy or discount.

**Radiology services** — This benefit Plan does not cover electron beam computed tomography (EBCT) also known as HeartScan®, ultrafast CT scan and peripheral bone density testing or scan. This benefit Plan does not cover the following except as described by medical policy screening or as provided in this benefit booklet, whole body CT scan, routine screening, or more than one routine ultrasound per pregnancy.

**Report preparation** — This benefit Plan does not cover charges for the preparation of medical reports or itemized bills or charges for duplication of medical records from the provider when requested by the member.

**Sex-change operations** — This benefit Plan does not cover services or supplies related to sex-change operations, reversals of such procedures, complications of such procedures, or services received prior to any such operation.

**Sexual dysfunction** — This benefit Plan does not cover services, supplies, or prescription drugs for the treatment of sexual dysfunction or impotence.

**Taxes** — This benefit Plan does not cover sales, service, or other taxes imposed by law that apply to benefits covered under this benefit booklet.

**Temporomandibular joint surgery or therapy** — This benefit Plan does not cover surgical or non-surgical services, supplies or appliances related to temporomandibular joint therapy or surgery or orthognathic surgery, including invasive (internal) and non-invasive (external) procedures and tests regardless of the reason(s) such services are necessary.

**Third-party liability (subrogation)** — This Plan does not cover services and supplies which may be reimbursed by a third party, see ADMINISTRATIVE INFORMATION section for information.

**Travel expenses** — This benefit Plan does not cover travel or lodging expenses for the member, members family or the Physician except as provided under Human Organ and Tissue Transplant Services heading in the MEMBER BENEFITS section.

**Vision** — This benefit Plan does not cover any eyeglasses, contact lenses (even if there is a medical diagnosis which prevents the member from wearing contact lenses), or prescriptions for such services and supplies. This benefit Plan does not cover any surgical, medical, or hospital service and/or supply rendered in connection with any procedure designed to correct farsightedness, nearsightedness, or astigmatism. This benefit Plan does not cover vision therapy including, but not limited to, treatment such as vision training, orthoptics, eye training or training for eye exercises.

**War-related conditions** — This benefit Plan does not cover services or supplies necessary to treat disease or injury resulting from war, civil war, insurrection, rebellion, or revolution.

**Weight-Loss Programs** — This benefit Plan does not cover services related to weight loss programs, whether or not they are pursued under medical or Physicians supervision except as provided in the MEMBER BENEFITS section.

**Worker’s compensation** — This Plan does not cover services and supplies for a work-related accident or illness, see the ADMINISTRATIVE INFORMATION section.
Administrative Information

The Costs of Your Benefit Plan

How Costs are Established and Changed – The costs and fees described in this section are the monthly charges the member and/or employer must pay Anthem to establish, administer and maintain coverage and to pay claims for covered services. Anthem determines and establishes the required fees and charges. As this Plan is self-funded, the employer is responsible for paying claims covered by the Plan and responsible for paying the administrative fees to Anthem according to the terms of the Administrative Services Agreement. Employers may require their employees to contribute to these costs through payroll deduction.

How to File Claims

When a participating provider bills Anthem for covered services, Anthem, on behalf of the employer, will pay the appropriate charges for the benefit directly to the provider. The member is responsible for providing the participating provider with all information necessary for the provider to submit a claim. The member pays the applicable copayment to the provider when the covered service is received.

Out-of-Area Covered Services

Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain covered services outside of Anthem’s service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem’s service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from non-participating providers. Anthem’s payment practices in both instances are described below.

Inter-Plan Programs

Out-of-Area Services - Anthem has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever you obtain healthcare services outside of Anthem’s Service Area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Anthem’s Service Area, you will obtain care from healthcare Providers that have a contractual agreement (i.e., are “participating Providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from nonparticipating healthcare Providers. Anthem’s payment practices in both instances are described below.

BlueCard® Program - Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling Anthem’s contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you access covered healthcare services outside Anthem’s Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Anthem.

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

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

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

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation - When covered healthcare services are provided outside of Our Service Area by non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue’s nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

Exceptions - In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the healthcare services had been obtained within Our Service Area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

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

Where and When to Send Claims

A claim must be filed within 15 months 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.

Members should make copies of the bills for their own records and attach the original bills to the completed claim form. The bills and the claim form must be submitted to:

Anthem Claims
P.O. Box 5747
Denver, CO 80217

Upon the death of a member, claims will be payable in accordance with the beneficiary designation. If no such designation is in effect, claims payments will be payable to the member’s estate. If the provider is a participating provider, claims payments will be made to the provider.

Payment in Error

If Anthem makes an erroneous benefit payment, Anthem may require the member, the provider of services or the ineligible person to refund the amount paid in error. Anthem reserves the right to correct payments made in error by offsetting the amount paid in error against new claims. Anthem also reserves the right to take legal action to correct payments made in error.

General Provisions
Administrative Information and General Provisions

**Catastrophic Events** - In case of fire, flood, war, civil disturbance, court order, strike or other cause beyond Anthem’s control, Anthem may be unable to process member claims on a timely basis. No legal action or lawsuit may be taken against Anthem due to a delay caused by any of these events.

**Changes to the Benefit Booklet** - Anthem may amend this benefit booklet when authorized by an Anthem officer and Colorado State University. Anthem or the employer will notify the member of any amendments within 60 days following the effective date of the amendment. If the employer requests a change that reduces or eliminates benefits, such change must be requested in writing or signed by the employer. Anthem will subsequently send the member a new benefit booklet.

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

**Contracting Entity** - The subscriber hereby expressly acknowledges that the subscriber understands that the benefit booklet constitutes a contract solely between the subscriber and Anthem, 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 Anthem to use the Blue Cross and Blue Shield Service Mark, and in doing so, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association. The subscriber further acknowledges and agrees that the subscriber has not entered into the contract based on representations by any person other than an Anthem representative, and that no person, entity or organization other than Anthem will be held accountable or liable to the subscriber for any of Anthem’s obligations created under the benefit booklet. This paragraph does not create any additional obligations whatsoever on Anthem’s part other than those obligations created under other provisions of the benefit booklet.

**Discretionary Clause** - Anthem retains the discretion to determine eligibility for benefits and construe the terms of this benefit booklet. But where required by applicable law, Anthem’s determinations may be reviewed de novo (as if for the first time) in a subsequent appeal of legal action.

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

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

- Be wary of offers to waive copayments. This practice is usually illegal.
- Be wary of mobile health testing labs. Ask what the insurance company will be charged for the tests.
- Always review the Explanation of Benefits received from Anthem. If there are any discrepancies, call Anthem’s Member Services department.
- Be very cautious about giving the member’s health insurance benefits information over the phone.

If fraud is suspected, members should contact Anthem’s Member Services department.

Anthem reserves the right to recover any benefit payments paid on behalf of a member, and/or rescinding your membership under this benefit booklet retroactively as if it never existed, if the member has committed fraud or material misrepresentation in applying for benefits or receiving or filing for benefits.

**Independent Contractors** - Anthem has an independent contractor relationship with Anthem’s participating providers; physicians and other providers who are not Anthem’s agents or employees, and Anthem’s employees are not employees or agents of any of Anthem’s participating providers. Anthem has no control over any diagnosis, treatment, care or other service provided to a member by any facility or professional provider. Anthem is not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries...
suffered by the member while receiving care from any of Anthem’s participating providers by reason of negligence or otherwise.

Anthem has an independent contractor relationship with the member’s employer. The employer is not Anthem’s agent or employee, and Anthem’s employees are not employees or agents of the employer.

Anthem 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/behavioral health and substance abuse services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims payment or Member Services duties on Anthem’s behalf.

Network Access Plan - Anthem strives to provide an extensive provider network in Colorado that adequately addresses member’s health care needs. The Network Access Plan describes Anthem’s provider network standards for network sufficiency in service, access and availability, as well as assessment procedures Anthem follows in Anthem’s effort to maintain adequate and accessible networks. To request a copy of this document, call Anthem’s Member Services department at the number printed at the bottom of this page. This document is available on Anthem’s website or for in-person review at 700 Broadway in Denver, Colorado in the Member Services department.

Notice of Privacy Practices – The employer is committed to protecting the confidential nature of member medical information to the fullest extent of the law. In addition to various laws governing member’s privacy, they have their own privacy policies and procedures in place designed to protect member information. The employer is required by law to provide individuals with notice of their legal duties and privacy practices. To obtain a copy of this notice, contact the Colorado State University Benefits Unit.

No Withholding of Benefits for Necessary Care - Anthem does not compensate, reward or incent, financially or otherwise, Anthem’s associates for inappropriate restrictions of care. Anthem does not promote or otherwise provide an incentive to employees or physician reviewers for withholding benefit approval for medically necessary services to which the member is entitled. Utilization review and benefit coverage decision making is based on appropriateness of care and service and the applicable terms of this benefit booklet.

Anthem does not design, calculate, award or permit financial or other incentives based on the frequency of: (1) denials of authorization for benefits; (2) reductions or limitations on hospital lengths of stay, medical services or charges; or (3) telephone calls or other contacts with health care providers or members.

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

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

Reserve Funds - No member is entitled to share in any reserve or other funds that may be accumulated or established by Anthem, unless Anthem grants a right to share in such funds.

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

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

Anthem has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. Anthem will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. Anthem may not provide you with notice of overpayments made by them or you if the recovery method makes providing such notice administratively burdensome.
Administrative Information and General Provisions

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:

- The subscriber at the latest address in Anthem’s membership records.
- The subscriber’s employer, if applicable.

Workers’ Compensation

To recover benefits under workers’ compensation insurance for a work-related illness or injury, the member must pursue the member’s 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. Anthem may pay conditional claims during the appeal process if the member signs a reimbursement agreement to reimburse Anthem 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 benefit booklet, except for corporate officers who may opt out of Workers’ Compensation coverage, pursuant to state or federal law, prior to the illness or injury. This exclusion from benefits applies to expenses resulting from occupational accident(s) or sickness(es) covered under:

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

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

- The member fails to file a claim within the filing period allowed by the applicable law.
- The member obtains care that is not authorized by workers’ compensation insurance.
- The member’s 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.
- The member fails to comply with any other provisions of the Workers’ Compensation Act.

Automobile Insurance Provisions

Anthem will coordinate the benefits of this certificate with the benefits of a complying automobile insurance policy. A complying automobile insurance policy is an insurance policy approved by the Colorado Division of Insurance that provides at least the minimum coverage required by law, and one which is subject to the Colorado Auto Accident Reparations Act or Colorado Revised Statutes §§ 10-4-601 through 10-4-633. Any state or federal law requiring similar benefits through legislation or regulation is also considered a complying policy.

How Anthem Coordinates Benefits with Complying Policies - Member benefits under this certificate may be coordinated with the coverage’s afforded by complying policy. After any primary coverage’s offered by the complying policy are exhausted, Anthem will pay benefits subject to the terms and conditions of this certificate. If there is more than one complying policy that offers primary coverage, each will pay its maximum coverage before Anthem is liable for any further payments.

Members must fully cooperate with Anthem to make sure that the complying policy has paid all required benefits. Anthem may require members 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.

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

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

Anthem will also pay benefits under the terms of the certificate for injuries sustained by a member who is a non-owner-operator, passenger or pedestrian involved in a motor vehicle accident if that member’s injuries are not covered by a complying policy. In that event, Anthem may exercise the rights found in the ADMINISTRATIVE INFORMATION section, under the heading Third Party Liability: Subrogation.

Third Party Liability: Subrogation and Right of Reimbursement

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

Subrogation

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

- The plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

- You and your legal representative must do whatever is necessary to enable the plan to exercise the plan's rights and do nothing to prejudice those rights.

- In the event that you or your legal representative fail to do whatever is necessary to enable the plan to exercise its subrogation rights, the plan shall be entitled to deduct the amount the plan paid from any future benefits under the plan.

- The plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the plan's subrogation claim and any claim held by you, the plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

- The plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without the plan's prior written consent. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the plan.

Reimbursement

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

- You must reimburse the plan from any Recovery to the extent of benefits the plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the plan shall have a right of full recovery, in first priority, against any Recovery. Further, the plan’s rights will not be reduced due to your negligence.

You and your legal representative must hold in trust for the plan the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the plan immediately upon your receipt of the Recovery. You must reimburse the plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the plan.

If you fail to repay the plan, the plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the plan has paid or the amount of your Recovery whichever is less, from any future benefit under the plan if:

- The amount the plan paid on your behalf is not repaid or otherwise recovered by the plan; or
- You fail to cooperate.

In the event that you fail to disclose the amount of your settlement to the plan, the plan shall be entitled to deduct the amount of the plan’s lien from any future benefit under the plan.

The plan shall also be entitled to recover any of the unsatisfied portion of the amount the plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the plan will not have any obligation to pay the Provider or reimburse you.

The plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

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

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

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

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

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

**Duplicate Coverage and Coordination of Benefits**

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

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

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

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

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

The following are not Allowable Expense:

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

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

How We Determine Which Coverage is Primary and Which is Secondary - We will determine the primary coverage and secondary coverage according to the following rule: A plan that does not have order of benefit determination rules will always be primary unless the provisions of both plans state that the plan is primary.

Non-Dependent or Dependent

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

Active Employee, Retired or Laid-Off Employee

a. The plan that covers a person as an active employee, who is not laid off or retired, or a dependent of an active employee, is the primary plan.

b. If the secondary, or other plan, does not have this rule, and as result the plans do not agree on the order of benefits, this rule is ignored.

c. This rule does not apply if the section above of “Non-Dependent or Dependent” can determine the order of benefits.

COBRA or State Continuation Coverage

a. If a person whose coverage is provided in accordance with COBRA, or under a right of continuation according to state or federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree, is the primary plan and the plan covering that same person in accordance with COBRA, or under a right of continuation in accordance with state or other federal law, is the secondary plan.

b. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

c. This rule does not apply if the section above of “Non-Dependent or Dependent” can determine the order of benefits.

Longer or Shorter Length of Coverage

a. If the rules above do not determine the order of benefits, the plan that covered the person for the longer period of time is primary plan and the plan that covered the person for the shorter period of time is the secondary plan.

b. To determine the length of time a person has been covered under a plan, two (2) successive plans will be treated as one if the covered person was eligible under the second within twenty-four (24) hours after the first ended.

c. The start of a new plan does not include:

(1) A change in the amount or scope of a plan’s benefits;

(2) A change in the entity that pays, provides or administers the plan’s benefits; or
(3) A change from one type of plan to another (such as, from a single employer plan to that of a multiple employer plan).

d. The person’s length of time covered under a plan is measured from the person’s first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group will be used as the date from which to determine the length of time the person’s coverage under the present plan has been in force.

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

**Dependent Child Covered Under More Than One Plan**

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

a. For a dependent child whose parents are married or are living together, whether or not they have been married:
   
   (1) The plan of the parent whose birthday falls earlier in the calendar year, by month and day, is the primary plan; or
   
   (2) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
   
   (1) If the court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage, and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no health care coverage for the dependent child’s health care, but that parent’s spouse does, the spouse’s plan is primary. This item will not apply with respect to a plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
   
   (2) If the court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, paragraph a. above will determine the order of benefits;
   
   (3) If the divorce decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the depend child, paragraph a above will determine the order of benefits; or
   
   (4) If there is no court decree allocating responsibility for the child’s health care expenses of health care coverage, the order of benefits for the child are as follows:
      
      (a) The plan of the custodial parent;
      
      (b) The plan of the spouse of the custodial parent;
      
      (c) The plan of the noncustodial parent; and then
      
      (d) The plan of the spouse of the noncustodial parent.

c. For a dependent child covered under more than one plan of individuals who are not parents of the child, the order of benefits will be determined, as applicable, according to paragraph a. or b. above as if those individuals were the parents of the child.
d. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in the section above for “Longer or Shorter Length of Coverage” applies.

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

Rules for Coordination of Benefits

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

1. The primary plan must pay or provide its benefits as if the secondary plan or plans did not exist.

2. If the primary plan is a Closed Panel Plan, and the secondary plan is not a Closed Panel Plan, the secondary plan will pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary provider.

3. When multiple contracts providing coordinated coverage are treated as a single plan, this section only applies to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts.

4. If a person is covered by more than one secondary plan, each secondary plan will take into consideration the benefits of the primary plan, or plans, and the benefits of any other plan, which, has its benefits determined before those of that secondary plan.

5. Under the terms of a Closed Panel Plan, benefits are not payable if the covered person does not use the services of a closed panel provider, with the exceptions of medical emergencies and if there are allowable benefits available. In most instances, Coordination of Benefits does not occur if a covered person is enrolled in two (2) or more Closed Panel Plans and obtains services from a provider in one of the Closed Panel Plans because the other Closed Panel Plan (the one whose providers were not used) has no liability. However, Coordination of Benefits may occur during the claim determination period when the covered person receives emergency services that would have been covered by both plans.

Determining Primacy Between Medicare and Us

- We will be the primary payer for persons with Medicare age 65 and older if the policyholder is actively working for an employer who is providing the policy holder’s health insurance and the employer has 20 or more employees. Medicare will be the primary payer for persons with Medicare age 65 and older if the policyholder is not actively working, and the Member is enrolled in Medicare. Medicare will be the primary payer for persons with Medicare age 65 and older if the employer has less than 20 employees and the Member is enrolled in Medicare.

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

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

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

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

If Medicare is the primary payer due to Medicare primacy rules, then the rules of primacy for employees and their spouses will be used to determine the coverage that will pay second and third.

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

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

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

**Out Rights to Receive and Release Necessary Information** – We may release to, or obtain, from any insurance company or other organization or person any information which We may need to carry out the terms of this Booklet. Members will furnish to Us such information as may be necessary to carry out the terms of this Booklet.

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

**Duplicate Coverage and Coordination of Benefits Overpayment Recovery** - If We have overpaid for Covered Services under this provision, We will have the right, by offset or otherwise, to recover the excess amount from you or any person or entity to which, or in whose behalf, the payments were made.
Complaints, Appeals and Grievances

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

This section explains what to do if a member disagrees with Anthem’s denial, in whole or in part, of a claim, requested service or supply and includes instructions on initiating a complaint, filing an appeal or filing a grievance with Anthem.

Complaints

If a member has a complaint about any aspect of Anthem’s service or claims processing, the member should contact Anthem’s Member Services department. A trained representative will work to clear up any confusion and resolve the member’s concerns. A member may submit a written complaint to the address listed below. If the member is not satisfied with the resolution of their concerns by the Anthem Member Services associate, the member may file an appeal as explained under the heading Appeals in this section:

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

Appeals

While Anthem encourages members to file appeals within 60 days of the adverse benefit determination, the member’s written appeal must be received by Anthem within 180 days of the adverse benefit determination. Anthem will assign a Customer Advocate to assist the member in the appeal process. Members may send written appeals to the following address:

Anthem
Appeals Department
700 Broadway CAT CO105-540
Denver, CO 80273-0001

An appeal may be filed with or without first submitting a complaint. In the appeal, the member must state plainly the reason(s) why the claim or requested service or supply should not have been denied. The member 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 Anthem’s decision.

For a thorough, unbiased review, the member 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 the member.

Members may designate a representative (e.g., the member’s physician or anyone else of the member's choosing) to file any level of appeal review with Anthem on the member’s behalf. The member must give this designation to Anthem in writing.

Level 1 Appeal — This is an appeal in which Anthem appoints an internal person(s) not involved in the initial determination to review the denial of the claim, requested service or supply. A person that was previously involved with the denial may answer questions. The person(s) appointed to review a Level 1 Appeal involving utilization review shall consult with an appropriate clinical person(s) in the same specialty as would typically manage the case being reviewed. For utilization review issues, the member will receive a response to the member’s Level 1 Appeal within 20 workdays of receipt of the appeal request. Non-utilization review appeals will typically be resolved within 30 workdays.

Level 2 Appeal — This is an appeal of an adverse benefit determination that has not been resolved to the member’s satisfaction under the Level 1 Appeal process. The Level 2 Appeal must be requested within 60 calendar days after the member receives Anthem’s adverse determination from the Level 1 Appeal. The member may appear or be
Complaints, Grievances and Appeals

teleconferenced in to present testimony, introduce documentation the member believes supports their appeal and provide documentation requested by Anthem at a hearing concerning the appeal. The panel of reviewers shall include a minimum of three people and may be composed of Anthem associates who have appropriate professional expertise. A majority of the panel shall be comprised of persons who were not previously involved in the dispute; however, a person who was previously involved with the dispute may be a member of the panel or appear before the panel to present information or answer questions. In the case of utilization review appeals, the majority of the persons reviewing the appeal shall be health care professionals who have appropriate expertise. Such reviewing health care professionals shall meet the following criteria:

- Have not been involved in the care previously.
- Is not a member of the board of directors of the health plan.
- Have not been involved in the review process for the covered person previously.
- Do not have a direct financial interest in the case or in the outcome of the review.

Anthem will issue a copy of the written decision to the member and to the provider who submits an appeal on the member’s behalf, if any, within 50 workdays of Anthem’s receipt of the Level 2 Appeal request. A member or member’s representative has the right to request an expedited appeal of a utilization review decision when the time frames for a standard review would: seriously jeopardize the life or health of the covered person; jeopardize the covered person’s ability to regain maximum function; or for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. Typically the decision will be made within 72 hours. Expedited appeals will be evaluated by an appropriate clinical peer or peers who were not involved in the initial denial. Anthem will not provide an expedited review for retrospective denials.

**Level 3 Appeal** — These are conducted by an independent third party and are available only in those circumstances where benefits were denied and which have gone through the Anthem Level 2 Appeal process. To request a Level 3 Appeal, contact the Colorado State University’s Human Resources Department at the following address:

Colorado State University  
c/o Human Resources  
6004 Campus Delivery  
Fort Collins, CO 80523-6004

The request for a Level 3 appeal must be made within 60 calendar days of the Anthem Level 2 denial.

**Grievances**

A member may send a written grievance to the following address:

Anthem  
Quality Management Department  
700 Broadway MC0532  
Denver, CO 80273

Receipt of the member’s grievance will be acknowledged by Anthem’s Quality Management Department and the grievance will be investigated by Anthem’s Quality Management Department. Anthem treats each grievance investigation in a strictly confidential manner.

**Regulatory Inquiries**

As this benefit Plan is self-funded by the employer, it is typically not subject to regulation by the Colorado Division of Insurance. Nonetheless, for inquiries about health care coverage in Colorado, members may call the Division of Insurance between the hours of 8 a.m. and 5 p.m., Monday through Friday, at (303) 894-7490, or write to the Division of Insurance to the attention of the ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202.

**Binding Arbitration**

The binding arbitration provision is applicable to claims arising under all individual plans, governmental plans, church plans, plans or claims to which ERISA preemption does not apply, and plans maintained outside the United States. Any such arbitration will be governed by the procedures and rules established by the American Arbitration Association provided, however, that no formal discovery shall be allowed, unless agreed to by the parties. Members may obtain a copy of the Rules of Arbitration by calling Anthem’s Member Services department. The law of the
Complaints, Grievances and Appeals

state in which the benefit booklet was issued and delivered to the member shall govern the dispute. The decision in arbitration is binding upon both the member and Anthem. Judgment on the award given in arbitration may be enforced in any court that has proper jurisdiction. In the event any person subject to this arbitration clause initiates legal action of any kind, Anthem may apply for a court of competent jurisdiction to enjoin, stay or dismiss any such action and direct the parties to arbitrate in accordance with this provision.

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

Legal Action

Before a member takes legal action on a claim decision, the member must first follow the process outlined under the heading Appeals in this section and the member must meet all the requirements of this benefit booklet. To the extent required by applicable law, if you have exhausted all mandatory levels of review in the Appeals heading in this section, you may be entitled to have the claim decision reviewed de novo (as if for the first time) in any court with jurisdiction and to a trial by jury.

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

This section defines words and terms used throughout the benefit booklet to help members understand the content. Members should refer to this section to find out exactly how, for the purposes of this benefit booklet, a word or term is used.

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 between Anthem and the employer stating all of the terms and provisions applicable to group benefits. The final interpretation of any specific provision contained in this benefit booklet is governed by the Administrative Services Agreement.

Alcoholism/substance treatment center — a detoxification and/or rehabilitation facility licensed by the state.

Alternative/complementary care — therapeutic practices that are not currently considered an integral part of conventional medical practice. Therapies are termed Complementary 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, alcoholism treatment centers and other facilities bill for and regularly make available for the treatment of the member’s 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 usually injected with a local anesthetic drug such as Lidocaine.

Anniversary date — the annual date on which a group renews its benefit Plan.

Annual benefits open enrollment — the employer’s annual benefits open enrollment period, which is generally held in November with a January 1st effective date.
Anthem Blue Cross and Blue Shield — Rocky Mountain Hospital and Medical Service, Inc., a Colorado insurance company doing business as Anthem Blue Cross and Blue Shield. Also referred to as “Anthem”, “Us”, “We” or “Our”.

Appeal — a process for reconsideration of Anthem’s decision regarding a member’s claim.

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

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

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

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

Autism Treatment Plan — a plan for a Member by an Autism Services Provider and prescribed by a Doctor or psychologist in line with a complete evaluation or reevaluation of a Member's diagnosis; proposed treatment by type, frequency, and expected treatment; the expected outcomes stated as goals; and the rate by which the treatment plan will be updated. The treatment plan is in line with the patient-centered medical home as defined in state law.

Benefit 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 benefit booklet and any other Plan document, the terms of the benefit booklet control.

Benefit period — the number of days or units of service, such as two office visits per member’s benefit year, for which Anthem will provide benefits during a specified length of time.

Billed charges — a provider’s regular charges for services and supplies, as offered to the public generally and without any adjustment for any applicable participating provider discount or other discounts.

Biologically based mental illnesses — are schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder and panic disorder.

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 coverage’s 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.

Care management — a plan of medically necessary and appropriate health care, which is aimed at promoting more effective interventions to meet member 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 members, providers and Anthem to coordinate services deemed medically necessary for the member. 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.
Glossary

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

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

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

Coinsurance — a provision under which the subscriber and Anthem share costs incurred after the deductible is met, according to a specific formula.

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

Colorado State University Summary Plan Description — the document that describes benefits and privileges available to eligible employees.

Complaint — an expression of dissatisfaction with Anthem’s services or the practices of a 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 the member's 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, a member may be covered by the member's own policy, as well as a spouse's policy. Eligible medical expenses are covered first by a 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 a member must pay out of the member’s own pocket to a provider or a facility for each service. A copayment is usually a fixed amount that is 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 for out-of-pocket expenses, e.g., copayments and deductibles paid by a member.

Covered services — supplies or treatments which are:

- Medically necessary or otherwise specifically included as a benefit under this benefit booklet.
- Within the scope of the license of the provider performing the service.
- Rendered while coverage under this benefit booklet is in force.
- Not experimental/investigational or otherwise excluded or limited by the benefit booklet, or by any amendment or rider thereto.
- Authorized in advance by Anthem if such pre-certification is required by the benefit booklet.

Covered services are subject to the maximum allowed amount which is the maximum amount payable for covered services members receive, up to but not to exceed charges actually billed. If a service is not covered or if the member has exceeded their benefits for covered services, the provider is not limited by the maximum allowed amount and they can charge up to the billed amount.

Covered Transplant Procedures — any medically necessary human organ and stem cell/ bone marrow transplants and transfusions as listed as a covered service in this Benefit Booklet or as determined by Anthem.
including necessary acquisition procedures, harvest and storage, and including medically necessary preparatory myeloblastic therapy.

**Creditable coverage** — a qualified prior health coverage that an employee and/or dependent had within 90 days prior to the effective date of Anthem’s benefits. 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 not limited to, hospital services, physicians’ services, outpatient medical services, and laboratory and X-ray services.

**Cryocuff** — water-circulating pad with pump. A machine that circulates fluid through a specially designed pad to provide continuous cold or heat therapy to a specific area.

**Custodial care** — care provided primarily to meet the personal needs of the member. 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 which does not require continuing services of specialized medical personnel.

**Deductible** — an amount that is required to be paid by a subscriber before Anthem will begin to reimburse for covered services.

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

**Discharge planning** — the evaluation of a member’s medical needs and arrangement of appropriate care after discharge from a facility.

**Domestic Partner** — is an adult who shares a committed relationship with a person of the same or opposite gender and who is deemed eligible upon completion of the Affidavit of Domestic Partnership.

**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 benefits under this benefit 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 Anthem determines in its sole discretion to be experimental or investigational.

Anthem will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be experimental or investigational if it determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

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

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

- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as experimental/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.
- Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by Anthem. In determining whether a service is experimental or investigational, Anthem 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 Anthem considers or evaluates 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) Anthem has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational.

Explanation of benefits — also known as an EOB, a printed form sent by an insurance company to a member 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, denial of a benefit or service received from a provider.

Health benefit ID card — the card Anthem gives members with information such as the subscriber’s name, number and date issued.

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

**Health Insurance Portability and Accountability Act of 1996** — also known as HIPAA, this is a federal act regulating the requirements for strict privacy and security requirements.

**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 health care** — the special term for skilled nursing, occupational therapy and other health-related services provided at home by a certified home health agency.

**Home health services** — the following services provided by a certified home health agency under a plan of care to eligible members in their place of residence: 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.

**Hospice agency** — an agency 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 health care and follow-up bereavement services available 24 hours a day, seven days a week.

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

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

**Individual membership** — a membership covering one person (the subscriber).

**In-network** — a term for PPO providers or facilities that enter into a network agreement with Anthem.

**Inpatient 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.

**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.

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

**Long-term acute care facility** — an institution that provides an array of long-term critical care services to members with serious illnesses or injuries. Long-term acute care is provided for patients with complex medical needs. These include high-risk pulmonary patients with ventilator or tracheotomy needs, medically unstable members, extensive wound care or post-operative surgery wound members, and low level closed head injury members. LTAC facilities do not provide care for low intensity patient needs.
Managed care — a system of health care delivery the goal of which is to give members access to quality, cost effective health care while optimizing utilization and cost of services, and measuring provider and benefits performance.

Maternity services — services required by a member for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services. Delivery services include:
- Normal vaginal delivery.
- Cesarean section delivery.
- Spontaneous termination of pregnancy prior to full term.
- Therapeutic termination of pregnancy prior to viability.
- Complications of pregnancy.

Maximum allowed amount - the maximum amount that Anthem will allow for covered services that you receive. More information can be found in the ABOUT YOUR HEALTH COVERAGE section under Cost Sharing Requirements.

Maximum medical improvement — a determination at Anthem’s sole discretion that no further medical care can reasonably be expected to measurably improve a member’s condition. Maximum medical improvement shall be determined without regard to whether continued care is necessary to prevent deterioration of the condition or is otherwise life sustaining.

Medically necessary — an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that Anthem solely determines to be:
- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a physician and/or licensed, certified or registered provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of your illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- Not experimental/investigational.
- Not primarily for the convenience of the member, the member’s family or the provider.
- Not otherwise subject to an exclusion under this benefit 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 Policy and Technology Assessment - a process We use to review and evaluate new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the experimental / investigational status or Medical Necessity of new technology. Guidance and external validation of Anthem’s medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 doctors from various medical specialties including Our medical directors, doctors in academic medicine and doctors in private practice.

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

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

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 benefits under this benefit booklet.

Member’s benefit year — the member’s benefit year begins on the subscriber’s effective date, and expires on the following December 31; a new member’s benefit year commences on each subsequent January 1.

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

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

Nephritis — infection or inflammation of the kidney.

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

Non-participating provider — a provider defined as one of the following:
- A facility provider, such as a hospital, that has not entered into a PPO provider contract with Anthem
- A professional provider, such as a physician, who has not entered into a PPO provider contract with Anthem
- Providers who have not contracted or affiliated with Anthem’s designated subcontractor(s) for the services they perform under this benefit booklet

Occupational therapy — the use of educational and rehabilitative techniques to improve a member’s 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.

Organ 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.

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

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

Out-of-network — a term for non-participating providers or facilities that do not enter into a network agreement with Anthem. Services received from a non-participating provider, usually at a higher out-of-pocket expense to members than services rendered by a participating provider.

Out-of-pocket annual maximum — the cost sharing total a member may be liable for under this benefit booklet for medical expenses during a specified period. The out-of-pocket annual maximum is designed to protect members from catastrophic health care expenses. For each member’s benefit year, after the out-of-pocket annual maximum is reached, for most services payment will be made at 100 percent of the maximum allowed amount for the remainder of the member’s benefit year. Benefit period maximums, lifetime maximums under this benefit 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 the member’s home.

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

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

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

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

**Plan** — an employee welfare benefit plan established by the Employer, in effect as of the effective date, as described in the Plan documents, as they may be amended from time to time.

**Pre-certification (preauthorization)** — a process in which requests for services are reviewed prior to service for approval of benefits, length of stay and appropriate location.

**Premium or costs** — monthly charges that the member and/or employer must pay to establish, administer and maintain benefits.

**Prescription drugs** — prescription drugs include:

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

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

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

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

- **Multi-Source drug** — a brand-name prescription drug available from one manufacturer but there is at least one other equivalent (same active ingredients) generic drug available.

- **Pharmacy** — an establishment licensed to dispense prescription drugs 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 Anthem to provide covered drugs to members under the terms and conditions of this benefit booklet. An out-of-network pharmacy is not contracted with Anthem and benefits will be denied

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

- **Single Source drug** — a brand-name prescription drug available from one manufacturer with no generic equivalents.
Glossary

**Prescription drug maximum allowed amount** – is the maximum amount Anthem allows for any prescription drug. The amount is determined by Anthem using prescription drug cost information provided to Anthem by the Pharmacy Benefits Manager (PBM).

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

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

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

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

**Provider** — a person or facility recognized by Anthem as a health care provider and that 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 benefit booklet. Such services are subject to review by a medical authority appointed by Anthem. Other professional providers include, among others, certified nurse midwives, dentists, optometrists and certified registered nurse anesthetists. Services of such a provider must be among those covered by this benefit booklet and are subject to review by a medical authority appointed by Anthem.

**Facility provider** — there are two types of facility providers, inpatient and outpatient.

- **Inpatient facility provider** — a hospital, alcoholism treatment center, residential treatment center, hospice facility, skilled nursing facility or other facility which Anthem recognizes as a health care provider. These facility providers may be referred to collectively as a facility provider or separately as an alcoholism treatment center provider.

- **Outpatient facility provider** — a dialysis center, Veteran’s Administration or Department of Defense hospital, home health agency or other facility provider (except a hospital, alcoholism treatment center or hospice facility, skilled nursing facility or residential treatment center) recognized by Anthem 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 benefit booklet and are subject to review by a medical authority appointed by Us. Example: ambulatory surgery center.

**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 mastoplastic.

**Reconstructive surgery** — in this benefit 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 Recovery provisions of this benefit booklet.
Glossary

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

**Retail Pharmacy** – an establishment licensed to dispense prescription drugs and other medications (other than specialty pharmacy drugs) 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 the member.

**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 prior to specific elective surgeries. In some cases, the health coverage may require a second opinion prior to a specific elective surgery.

**Skilled nursing care facility** — an institution that provides skilled nursing care (e.g. therapies and protective supervision) for uncontrolled, unstable or chronic condition members. 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 care for high intensity member medical needs, or members that 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.

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

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

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

**Speech therapy (also called speech pathology)** — services used for 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 or common law spouse.

**Sub-acute medical care** — medical care that requires less care than a hospital but often more care than a skilled nursing facility. Sub-acute medical care can be in the form of “transitional care” when a member’s condition is improving, but the member is not ready for a skilled nursing facility or home health care.

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

**Subscriber** — the member in whose name the membership with Anthem is established.

**Summary of Benefits** — the document, found at the beginning of the benefit booklet, which identifies the type of benefits, copayment, 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, microsurgery (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 for required surgical services provided during a covered surgical procedure. Anthem, at its sole discretion, determines which surgeries do or do not require a surgical assistant.

**Therapeutic Care** - for purposes of the Autism Spectrum Disorders, this type of care is provided by a speech, occupational or physical therapist, or an Autism Services Provider. Therapeutic Care includes speech, occupational, and applied behavior analytic and physical therapies.

**Transplant Benefit Period** - the Transplant Benefit Period starts one day prior to a covered transplant procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network transplant Provider agreement.

**Ultrasound** — a radiology imaging technique that uses high frequency sound waves to see organs or the fetus in a pregnant woman.

**Urgent care** — care 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 specific benefit booklet exclusion), and review of a member’s medical circumstances when 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.
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**Point-of-Service PPO Plan**

Colorado State University

Colorado State University Member Services 800-542-9402

www.Anthem.com

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Behavioral Health Program

*When you need a hand with life’s challenges*

Everyone needs help from time to time dealing with life’s challenges. When you have physical problems, you go to the doctor. But where do you turn when you have an emotional concern? What do you do when talking with a friend or relative doesn’t help? That’s when Anthem Blue Cross and Blue Shield’s behavioral health program can help. This program includes a full continuum of managed behavioral healthcare benefits as part of your health insurance plan. Call Us. We’re here to help.

**Program services**

Our program is designed to provide you with access to personalized care for your behavioral health needs. By calling Our toll-free number, you and your covered dependents have access to a full range of quality, affordable mental health and substance abuse treatment services. You can get help for alcohol and drug abuse, along with a variety of mental health concerns, including depression and anxiety.

While specific services and benefits depend on your health plan, services typically include:

- Outpatient assessment and treatment
- Alternate care such as partial hospitalization, intensive outpatient and day treatment programs
- Inpatient assessment and treatment
- Individual and group treatment
- Crisis intervention
- Treatment follow-up and aftercare

**Statewide network**

When you call Our toll-free number, Our staff will assist you in accessing Our behavioral healthcare network. Our network includes highly trained providers. To qualify, these providers must meet a number of rigorous quality standards. These standards include professional degrees and licenses, as well as minimum length of time in practice.

Located in urban and rural areas throughout the state, Our network includes:

- Psychiatrists
- Psychologists
- Certified substance abuse counselors
- Licensed social workers
- Professional clinical counselors
- Prescriptive nurses

Our network also includes hospitals, community mental health centers and other treatment programs. Through these extensive resources, We can provide you with access to personalized care to meet your specific needs. And, because Our network is so large, the care you need is never far away.

**Easy access to care**

Using the program is easy, convenient and confidential. Just call Anthem’s behavioral health toll-free number. When you call, a member of Our staff will help you choose a provider who is convenient to your home or workplace. If you need immediate assistance, members of Our clinical staff are available 24 hours a day to help you at 1-800-424-4014. In the event of an emergency, call 9-1-1 or go directly to the nearest hospital.
Important information about Our program
Here is some important information to keep in mind when accessing Anthem’s behavioral health programs and services:

- We recognize there may be times when you feel that emergency care is needed, requiring immediate medical attention. In these situations, obtain the emergency care and notify Us or have your provider notify Us, as soon as possible.
- Please do not hesitate to contact Anthem if you have any questions about your behavioral health benefits.

When you call, a specially trained member of Our staff will be able to preapprove medically necessary services and help you obtain the highest benefit payment you’re eligible for under the terms of your plan. Some plans always require pre-approval — called pre-certification — so it makes sense to always call Anthem’s behavioral health toll-free number before you receive any behavioral healthcare treatment. You should refer to your Benefit Booklet for a full description of benefits, limitations and exclusions.

Frequently asked questions

How do I get care?
Just call Anthem’s behavioral health toll-free number. A member of Our staff can help you select the network provider who meets your needs and is convenient to your home or workplace. If you are admitted, you or your provider should contact Us within 24 hours to determine if you have coverage for the services received. If you’re not sure whether you have an emergency, call Anthem first. Our clinical staff is available to assist you at all hours of the day and night, every day of the year.

Must all behavioral healthcare services be pre-certified?
Members must call for pre-certification of all inpatient services; however, outpatient services do not require pre-certification. In the case of a situation where emergency care is needed all members should contact Us as soon as reasonably possible.

Do I need a referral from my doctor?
While referrals from your doctor are welcome, they are not required. You can call Anthem’s behavioral health toll-free number directly to access mental health or, if applicable, substance abuse care.

How can I prepare for my appointment?
At a therapy appointment, the goal is to help you create positive change in your life by addressing problems you identify. Your therapist will help you sort through your concerns, set goals and explore solutions to the difficulties you are experiencing. Follow these helpful tips to prepare for your first appointment:

- Start by thinking about why you decided to ask for help at this time. When did the problem begin? Did something stressful happen, such as a death in the family or problems with work or school?
- Think about similar concerns you’ve had in the past and try to recall how you dealt with the problem and what the outcome was.
- Try to come up with a goal for treatment before your first appointment begins. For example, perhaps your goal is to feel happier or improve your health.
- Most importantly, keep your appointment! Seeking help takes courage. Consider it an investment in yourself.

What about confidentiality?
At Anthem, We treat all records and services with the strictest confidence. The personal information that you share is completely confidential unless you authorize its disclosure if applicable law allows disclosure.
What about my rights?
Anthem has a Rights & Responsibilities statement that was created based on feedback from members and in accordance with regulatory and accreditation agencies. You may obtain a copy of this statement from your provider. Alternatively, a copy of the statement may appear in your health plan newsletter or Benefit Booklet.

How can I submit compliments or complaints about services that I have received?
The primary goal of Our program is to make sure you receive the best care for your specific situation, quickly and easily. We want to recognize Our staff and providers for compliments received, so We encourage you to contact Us by calling Our toll-free number. Once in a while however, you may have a complaint about services or disagree with a decision. If this happens, call right away. We’ll work with you to resolve your concern.

We’re here to help! Just call Anthem’s behavioral health toll-free number at (800)-424-4014
BlueCard Program

Across the country. Around the world. You take your health care coverage with you
When you’re a Blue Cross and Blue Shield Plan member, you take your health care benefits with you — across the country and around the world. The BlueCard Program gives you access to doctors and hospitals almost everywhere, giving you the peace of mind that you’ll always find the care you need.

You have the power to choose what’s right
As a Blue Plan member, you have more freedom to choose the doctors and hospitals that best suit you and your family. Your membership gives you a world of choices. More than 85 percent of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield plans. Whether you need care in urban or rural areas you’re covered. Outside of the U.S., you have access to doctors and hospitals in more than 200 countries.

Designed to keep you healthy and save you money
In many cases, when you travel or live outside your Blue Cross and Blue Shield Plan’s service area, you can take advantage of savings the local Blue Plan has negotiated with doctors and hospitals in the area. You should not have to pay any amount above these negotiated rates. Also, you should not have to complete a claim form or pay up front for your health care services, except for those out-of-pocket expenses (like non-covered services, deductible and coinsurance) that you’d pay anyway.

With the BlueCard Program, you can locate doctors and hospitals quickly and easily. Have your Blue Cross and Blue Shield Plan ID card handy, and do one of the following:
- Visit the BlueCard Doctor and Hospital Finder Web site at www.BCBS.com to locate doctors and hospitals along with maps and directions to find them. — OR —
- Call BlueCard Access at 1-800-810-BLUE for the names and addresses of doctors and hospitals in the area where you or a covered dependent need care.

Always use a BlueCard participating doctor or hospital to make sure you receive the highest level of benefits.

Take care of your health, wherever you are within the U.S.
- Always carry your current Blue Cross and Blue Shield Plan ID card for easy reference and access to service.
- In an emergency, go directly to the nearest hospital.
- To find names and addresses of nearby doctors and hospitals, visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call BlueCard Access at 1-800-810-BLUE.
- Call your Blue plan for pre-certification or prior authorization, if necessary. (Refer to the phone number on your Blue Plan ID card.) It is different from the BlueCard Access number listed in the previous step.
- When you arrive at the participating doctor’s office or hospital, simply present your Plan ID card.

After you receive care, you should not have to complete any claim forms. Nor should you have to pay up front for medical services other than the usual out-of-pocket expense (non-covered services, deductible, co-payment, and coinsurance). Your Blue Cross and Blue Shield Plan will send you a complete explanation of benefits.
**Around the world**

Like your passport, you should always carry your Blue Cross and Blue Shield Plan ID card when you travel or live outside the U.S. The BlueCard Worldwide program provides medical assistance services and access to doctors, hospitals, and other health care professionals around the world. When outside the U.S., follow the same simple process as in the U.S., with the following exceptions:

- In most cases, you should not need to pay up front for inpatient care at BlueCard Worldwide hospitals. You are responsible for the usual out-of-pocket expenses (non-covered services, deductible and co-insurance). The hospital should submit your claim.
- You pay the doctor or hospital for inpatient care at non-BlueCard Worldwide hospitals, outpatient hospital care, and other medical services. Then, complete an international claim form and send it to the BlueCard Worldwide Service Center. The claim form is available from your Blue Cross and/or Blue Shield plan or online at [www.BCBS.com](http://www.BCBS.com).

You can take advantage of these added features outside the U.S.

- You can call (800)-810-BLUE or collect at (804)-673-1177, 24 hours a day, seven days a week for information on doctors, hospitals, and other health care professionals or to receive medical assistance services around the world.
- A medical assistance coordinator, in conjunction with a medical professional will make an appointment with a doctor or arrange hospitalization if necessary.

Coverage may vary for each Blue Cross and/or Blue Shield plan, so be sure to check with your Plan before leaving the U.S.
Your Prescription Drug Benefits

Offering convenient access to quality prescriptions at affordable prices

Your health plan benefits include a prescription program that is brought to you through Anthem Prescription Management. When you need a prescription filled, follow these simple steps:

- Take your prescription to a network pharmacy.
- Present your health plan ID card.
- Pay your copayment.

Comprehensive Formulary

Your prescription benefits come with a comprehensive formulary that includes hundreds of brand name and generic medications. The formulary is continuously updated based on best outcomes and recommendations by a pharmacy and therapeutics committee of practicing physicians and clinical pharmacists.

Extensive Pharmacy Network

We provide our health plan members with an extensive retail pharmacy network called Anthem Rx Network. This provides members access to more than 53,000 chain and independent pharmacies nationwide. Members can have prescriptions filled at home and while traveling across the United States.

Prescription Mail Service

Anthem Rx Direct is the name of your mail service pharmacy. It is designed for patients using continuous therapy medications like those used to treat asthma, diabetes, high blood pressure or arthritis.

The Anthem Rx Direct mail facility uses the most technically advanced methods for dispensing medications. All prescription orders are processed promptly, checked for safety and accuracy by registered pharmacists, and delivered in a confidential, secure package anywhere in the United States. With each order filled, you'll receive an easy order envelope. When it's time to refill, simply mail in the envelope or phone in your order. To get started, please ask your doctor to write your prescription for the maximum 90-day supply that is available through mail order. Note: some prescriptions may not be available for a 90-day supply.

Convenient Web Access

You may also access information about your prescription benefits by going to our web site at www.anthemprescription.com. Here, you can conveniently locate participating pharmacies, search the online formulary, and order over-the-counter products at a discount through the link to www.CVS.com.

Questions and Answers

Q. What is the first way I can save with my prescription benefits?
A. You'll receive lower pricing for prescriptions by using Anthem Rx Network pharmacies. These lower prices automatically apply to health plan members whenever you show your health plan ID card.

Q. What is the second way I can save on prescriptions?
A. You can also save when you request generic medications, if applicable, rather than brand name medications from your doctor or pharmacist.

Q. What is the third way I can save on prescriptions?
A. Your prescription mail service provides more days’ supply with fewer copayments. You'll typically save at least one copayment on each prescription filled by the Anthem Rx Direct mail service pharmacy.

Q. What are generic medications?
A. A generic medication is a product that contains the same active ingredients as its brand name counterpart, in the same dosage, form and strength.
Q. Do generic medications have the same quality as the brand-name medication?
A. Before any generic medication can be sold in the United States, the U.S. Food and Drug Administration (FDA) requires the medication to meet specifications for identity, strength, quality, purity and potency.

Q. Are generic medications as effective as the brand-name medications?
A. Yes. Use generics with confidence. Although generics can differ in shape, size and color, the generic medication must be absorbed and utilized by your body in the same way as the brand-name medication.

Q. How can I request a generic medication?
A. Your physician and pharmacist are the best sources of information about generic medications. Simply ask your physician or pharmacist if your prescription can be filled with an equivalent generic medication.

Q. Why are generic medications less expensive?
A. Normally, a generic drug can be introduced to the market only after the expiration of the patent on its counterpart brand name drug. Manufacturers of generics generally price their products below the cost of the counterpart brand-name medications.

Offering you convenient access to quality prescriptions at affordable prices helps Us achieve Our mission of improving the health of the people We serve. We appreciate the opportunity to serve you!