

Welcome

Welcome to Anthem Blue Cross and Blue Shield, where our mission is to improve the health of the people we serve. You have enrolled in a quality health benefit program that pays for many of your health care expenses, including most expenses for physician and outpatient care, emergency care and hospital inpatient care.

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

For questions about your coverage, please call our customer service department at (888) 231-5046 or visit our website at www.anthem.com. This information is also located on the member's ID card.

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



James E. Oatman
VP and GM West Markets
Individual Business
Anthem Blue Cross and Blue Shield

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Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc.
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Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

Acceptance of coverage under this certificate constitutes acceptance of its terms, conditions, limitations and exclusions. Members are bound by all of the terms of this certificate.

Your health benefit coverage is defined in the following documents:

- This certificate, the *Health Benefit Plan Description Form* and any amendments or endorsements thereto.
- The Enrollment Application/Change Form for the subscriber and the subscriber's dependents.
- The health benefit ID card.

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 certificate. In the event of any question as to the interpretation of any provision of this certificate, 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 certificate.

This certificate is not a Medicare Supplement policy. If you are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Anthem. Contact our customer service department at (888) 231-5046 for information on how to obtain this guide.

Value-Added and Incentive Programs

We may offer health or fitness related programs to Our members, through which you may access discounted rates from certain vendors for products and services available to the general public. Products and services available under this program are not Covered Services under the Plan but are in addition to plan benefits. As such, program features are not guaranteed under your Certificate and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive. In addition, we may offer incentives to members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include, but are not limited to, enrolling to automatically pay premiums electronically instead of receiving a bill every month.

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Member Rights and Responsibilities

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.*

As a member, you have the right to:

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

As a member, you have the responsibility to:

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

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.

About Your Health Coverage

About Your Health Coverage

This is a Preferred Provider Organization (PPO) health insurance coverage, which means members have in-network (PPO) and out-of-network (non-PPO) benefits. In-network benefits are services provided to members by providers who are participants in the Anthem network as described under the heading "PPO Providers" in this section. Out-of-network benefits are those provided to members by providers who are not participants in the Anthem network.

This PPO coverage offers great flexibility because members may choose how to use their benefits and to control their out-of-pocket expenses. When members use their PPO in-network benefits, they receive the highest level of benefits at the lowest cost. The *Health Benefit Plan Description Form* lists payment levels for both in and out-of network care. Anthem publishes a directory of PPO and Participating Providers. A member can get a directory from Anthem. A member may call the customer service number that is listed on their identification card or may write Anthem and ask for a directory. A member may also search for a Provider online at www.anthem.com.

Providers

This PPO coverage covers care provided by primary care physicians and specialty care providers. To see a primary care physician, simply visit any network physician who is a general or family practitioner, internist, or pediatrician. Your policy also covers care provided by any specialty care provider you choose. Specialty care providers are any covered providers other than the primary care physicians listed above. Referrals are never needed to visit any specialty care provider.

PPO Providers

Providers who have entered into a network agreement with Anthem are PPO providers. Services provided by a PPO provider are considered in-network. When members visit a PPO provider they have lower out-of-pocket expenses. A PPO provider will bill Anthem directly and accept Anthem's contracted amount as payment in full. The contracted amount is the dollar amount approved by Anthem for a specific covered service. The PPO provider will also coordinate the member's care. Member in-network cost sharing responsibilities to PPO providers can be found on the Health Benefit Plan Description Form under the heading "In Network." Members are responsible for determining if their provider is a PPO provider. Members may visit our website at www.anthem.com or call our customer service department for provider information.

Using a PPO provider in our PPO network usually means the member pays a lower coinsurance amount than using a non-PPO provider. A provider may be a PPO provider for some types of services, but not other services. It is the member's responsibility to determine if the provider chosen is a PPO provider for the services to be rendered. The member can call Anthem's customer service department to determine who is a PPO provider for a particular service. There are a limited number of services and supplies for which Anthem does not have arrangements with a PPO provider. The counties in which Anthem does not have PPO providers for such services and supplies can be obtained by calling our customer service department. In these circumstances, if Anthem does not inform the member of an alternative for obtaining the service from a non-PPO or non-participating provider, the member may seek services from a non-PPO or non-participating provider. 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 a reasonable distance to receive care from a PPO or participating provider. Under these circumstances, if the member knowingly chooses to obtain the service from a non-participating provider, the member will be responsible for paying any charges from the non-participating 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 Provider.

Non-PPO providers are those who have not entered into a network agreement with Anthem. Services provided by a non-PPO provider are considered out-of-network. When members visit a non-PPO provider they may have higher out-of-pocket expenses. Members' out-of-network cost sharing responsibilities to non-PPO providers can be found on the Health Benefit Plan Description Form under the heading "Out-of-Network." Two types of non-PPO providers exist:

About Your Health Coverage

Participating Providers

Non-PPO providers who have entered into a participating agreement with Anthem to bill Anthem directly for covered benefits are participating providers. The participating agreement differs from the network agreement that PPO provider's sign. Although Anthem has contracted with participating providers, they are non-PPO providers. Participating providers agree to accept our contracted amount as payment in full. When benefits are applied they are paid as out-of-network.

Non-Participating Providers

Providers who have not signed agreements with Anthem are non-participating providers. Members may be obligated to pay more out-of-pocket expenses when they visit a non-participating provider. Non-participating providers do not have to accept Anthem's maximum benefit allowance as payment in full. They may "balance bill" the member directly for any amount over Anthem's maximum benefit allowance for a covered service. Members must pay any difference between Anthem's maximum benefit allowance and the non-participating provider's billed charges. To obtain information as to Anthem's reimbursement rates for a non-participating provider for specific covered services, the member may contact Anthem's customer service department.

Anthem reserves the right to pay the benefits of this Certificate directly to Non-Participating Providers, whether you have authorized assignment of benefits or not. Anthem may require a copy of the assignment of benefits for our records. These payments fulfill Anthem's obligation to the member for those services.

Cost-Sharing Requirements

Cost-sharing refers to how Anthem and its members share the cost of health care services. It defines what Anthem is responsible for paying and what the member is responsible for paying. Members meet their cost-sharing requirements through the payment of deductibles, copayments and coinsurance (as described below). Cost-sharing requirements depend upon the choices the member makes in accessing services. For example, if the member chooses to use a PPO provider or facility, the member's out-of-pocket expenses may be less than if the member chooses a non-PPO provider or facility. Members' applicable cost sharing requirements are based on the allowable charge.

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, PPO providers and non-PPO participating providers agree to accept Anthem's maximum benefit allowance as payment in full for covered services. Anthem determines a maximum benefit allowance for all procedures performed by providers. For example, the hospital may charge \$12,000 for a procedure (its billed charge) and Anthem's maximum benefit allowance for that procedure is \$8,000. The deductible, copayment and coinsurance are based on the maximum benefit allowance of \$8,000, not the hospital's billed charge of \$12,000. In this example, the member's out-of-pocket costs would be lower if the member uses a participating provider.

In addition to accepting Anthem's maximum benefit allowance, many participating providers also give Anthem additional discounts. These additional discounts help control health care costs and benefit members. The discounts allow Anthem to offer more extensive benefit coverages with lower deductibles coinsurance amounts. These discounts are taken into account in a variety of ways in determining the amount members pay for health care.

Using the example described above, if the participating hospital charges \$12,000 for a procedure and the maximum benefit allowance is \$8,000, any additional discounts are deducted, the deductible and coinsurance are then subtracted and the balance is paid by Anthem. **If a member does not use a participating provider, any amount over the maximum benefit allowance is the member's responsibility (unless Anthem does not have a participating provider to provide the service, as explained above).**

About Your Health Coverage

Discounts allow Anthem to offer more extensive coverages with lower deductibles and coinsurance amounts and make it possible for Anthem to offer a lower-cost benefit coverage to members.

The contracts between Anthem and its providers include a “hold harmless” clause, which provides that a member cannot be responsible to the provider for claims expenses owed by Anthem for health care services covered under this certificate.

Allowable Charge

Reimbursement for benefits paid under this coverage, except as provided below, is limited to the allowable charge. The allowable charge is the dollar amount determined and approved by Anthem for covered services and procedures. Members’ applicable cost sharing requirements are based on the allowable charge.

For PPO and participating providers, the allowable charge is the contracted amount. PPO and participating providers have signed agreements to accept the contracted amount as payment in full. The contracts between Anthem and its providers include a “hold harmless” clause that provides that a member cannot be liable to the provider for moneys owed by Anthem for health care services covered under this certificate.

For non-participating providers, the allowable charge is the maximum benefit allowance. The member must pay any difference between Anthem’s maximum benefit allowance and the non-participating provider’s billed charge, except as provided below.

NOTE: Anthem will reimburse covered services received from a non-participating provider on the basis of billed charges rather than maximum benefit allowance in the following circumstances:

- **Emergency care (where rendered either within or outside the State of Colorado)**
- **Where in-patient hospital care at a non-participating provider is necessary due to the nature of the treatment**
- **Where in-patient hospital care at a non-participating provider is necessary due to participating provider hospital capacity**

In all other situations the maximum benefit allowance does apply.

Individual Deductible

A deductible is a specified amount of expense for covered services that the member must pay within each calendar year before Anthem provides benefits under this certificate. The deductible amount is listed on the *Health Benefit Plan Description Form*.

There are two separate deductibles: one for in-network PPO providers and one for out-of-network providers. These deductible amounts are included in the member’s Out-of-Pocket annual maximum as explained below under **Out-of-Pocket Annual Maximum**. Charges from a non-PPO provider cannot be applied toward meeting the PPO deductible, and charges from a PPO provider cannot be applied toward meeting the non-PPO deductible. Before Anthem provides payment for covered services, each member will need to satisfy a new deductible each calendar year.

Family Maximum Deductible

Under a family membership (two (2) or more members enrolled), once two (2) or more members’ allowable charges that applied to their individual deductible, combine to equal the family maximum deductible, no further deductible will be required for all enrolled members for the remainder of that year. However, no one person can contribute more than their individual deductible amount to the family maximum deductible.

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Coinsurance

The member pays a percentage of charges for covered services as listed on the *Health Benefit Plan Description Form*. This percentage is called coinsurance.

Coinsurance is required for covered services until the out-of-pocket annual maximum is reached for each calendar year. Until the out-of-pocket annual maximum is reached, the member pays the remaining percentage. Once the out-of-pocket annual maximum is reached, Anthem pays 100 percent of any remaining eligible charges for the remainder of the calendar year. In-network and out-of-network coinsurance amounts are separate and do not accumulate toward each other.

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 in the Health Benefit Plan Description Form. Members are responsible for making copayments directly to the provider. 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.

Out-of-Pocket Annual Maximum

The out-of-pocket annual maximum is designed to protect members from catastrophic health care expenses. The *Health Benefit Plan Description Form* describes in detail the charges that count towards the out-of-pocket annual maximum.

Family Out-of-Pocket Annual Maximum

Under a family membership (2 or more members enrolled), once 2 or more members' allowable charges that applied to their individual out-of-pocket annual maximum, combine to equal the family out-of-pocket annual maximum, no further copayments or coinsurance will be required for all enrolled members for the remainder of that year. However, no one person can contribute more than their individual out-of-pocket annual maximum amount to the family out-of-pocket annual maximum.

Benefit Period Maximum

Some covered services have a maximum number of days, visits or dollar amounts that Anthem will allow during a calendar year. These maximums apply even if the member has satisfied the applicable out-of-pocket annual maximum. See the *Health Benefit Plan Description Form* for those services which have a calendar year maximum.

Lifetime Maximum

Anthem will not pay for covered medical or pharmacy services once the member has met the lifetime maximum Anthem payment allowance, even if the member has satisfied the applicable out-of-pocket maximum. Specific dollar amounts for lifetime maximum benefits may be found in the *Health Benefit Plan Description Form*. The Anthem lifetime maximum payment allowance applies to any payments that Anthem makes for covered services under this certificate, or any Anthem certificate. If the member replaces any Anthem individual medical Policy with another Anthem individual medical Policy, any benefits applied toward the member's lifetime maximum benefit of the prior policy will be applied toward the member's lifetime maximum benefit of the new Policy.

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Managed Care Features

Managed care is a system of health care delivery with the goal to give members access to quality, cost effective health care while optimizing utilization and cost of services, and measuring provider and coverage performance. Anthem uses a variety of administrative processes and tools, such as preauthorization for health care services, care management, concurrent hospital review and disease management, to help determine the most appropriate use of the health care services available to our members. This section of the certificate explains how these managed care features are used and guides members through the necessary steps to take to obtain care. Additional information on how a member should proceed in case of an emergency can be found in the **MEMBER BENEFITS** section.

This certificate 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.

Benefits provided under this coverage 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 coverage. 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 whether a particular service is covered. Anthem will assist the member by determining what services are covered under the member's chosen coverage and what services are excluded from the health coverage.

Medically Necessary Health Care Services - Subject to a member's right to appeal, as described in the **COMPLAINTS, APPEALS AND GRIEVANCES** section, Anthem determines whether services, procedures, supplies or visits are medically necessary. Only medically necessary services, procedures, supplies or visits are covered by the member's coverage. 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 at www.anthem.com to view a list of services that are considered medically necessary. The benefits, exclusions and limitations of a member's coverage take precedence over medical policy.

Certain procedures, diagnostic tests, durable medical equipment, home health, home IV services and medications require preauthorization. The current list of the items can be found on Anthem's web site. See the **Appropriate Place and Preauthorization** section for additional details.

Experimental/Investigational and/or Cosmetic Procedures - Anthem will not pay for any services, procedures, surgeries or supplies that it considers experimental/investigational and/or cosmetic. Providers and members may go to Anthem's website at www.anthem.com 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 Preauthorization

Health care services may be provided in an inpatient or outpatient setting, depending on the severity of the medical condition and the services necessary to manage the condition in a given circumstance. Anthem covers care received in both environments provided the care received is a Covered service, is appropriate to the setting and is medically necessary. Inpatient settings include hospitals, skilled nursing facilities and hospice facilities. Outpatient settings include physicians' offices, ambulatory surgery centers, home care and home hospice settings. Some Covered services must be received from a designated facility, for example this includes but is not limited to bariatric surgery or human organ transplants. To determine which Covered

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services must be received from a designated facility, contact customer service. Covered services received from a non-designated facility may be denied or paid at a lower amount.

Preauthorization is a process Anthem uses to determine if a requested service or supply is a covered benefit and that the member's care is provided in the most medically appropriate setting. The preauthorization process may set limits on the care to be given. Preauthorization is required prior to an admission to a hospital or before receiving certain procedures or services. Some drugs also require preauthorization.

The PPO or participating provider who schedules an admission or orders the procedure or service is responsible for obtaining preauthorization. The member's health care provider must contact Anthem for preauthorization. To determine which inpatient admission and outpatient procedures and/or drugs require preauthorization, and/or to be sure that preauthorization has been obtained, the member may contact Anthem at the customer service number listed on the members ID card.

Inpatient Admissions - Inpatient admissions require preauthorization and concurrent review for all inpatient stays. The member's health care provider must call the number for **Provider Authorization** on the member's health benefit ID card to request preauthorization. Anthem will review the request for preauthorization. If the inpatient stay is approved, all benefits available under the member's coverage 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.

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

If Anthem does **not** grant preauthorization, the member will be held financially responsible for all inpatient stay charges. The member or the member's representative may appeal our preauthorization decision by following the procedure outlined in the **COMPLAINTS, APPEALS AND GRIEVANCES** section of this certificate.

Scheduled Admissions - The member's health care provider must obtain preauthorization prior to the admission from Anthem for all scheduled inpatient admissions as well as concurrent reviews for continued stays past the number of days authorized. Preauthorization 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 Emergency admission within one business day 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 Emergency admissions include admissions involving accidents. Failure to notify Anthem within one business day after the inpatient Emergency admission, unless the member is unable to do so, may result in denial of coverage when services are provided from a Non-Participating Provider

Inpatient admissions include acute care facilities (hospitals), rehabilitation facilities, long-term care acute facilities, sub acute facilities, rehabilitation facilities, skilled nursing facilities and inpatient hospice.

Outpatient Procedures- Many procedures on an outpatient basis must be preauthorized. The member's health care provider must contact Anthem for preauthorization. Members may go to Anthem's website or call Anthem's customer service department for a list of outpatient procedures and services that require preauthorization. The member's health care provider must call the number for **Provider Authorization** on the member's health benefit ID card to request preauthorization. These services may be performed in a hospital on an outpatient basis or in a freestanding facility, such as an ambulatory surgery center.

If Anthem does **not** grant preauthorization, the member will be held financially responsible for all charges related to the outpatient procedure. The member or the member's representative may appeal our

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preauthorization decision by following the procedure outlined in the **COMPLAINTS, APPEALS AND GRIEVANCES** section of this certificate.

Upon receipt of a preauthorization 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 preauthorization 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 preauthorization and at the place authorized. If the preauthorization period expires, or if additional services are requested, the provider must contact Anthem to request another authorization.

A preauthorization that a service requested meets medical necessity criteria **does not guarantee** that payment will be allowed. Fraud or abuse, or a subsequent change in eligibility, could cause a denial of payment. When Anthem receives the member's claim(s), Anthem will review them against the terms of this certificate.

The member or the member's representative may appeal our preauthorization decision by following the procedure outlined in the **COMPLAINTS, APPEALS AND GRIEVANCES** section.

Appropriate Length of Stay

With respect to the payment of benefits, 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. By using these guidelines and increasing your familiarity with your benefit plan, you are more likely to receive the appropriate level of care and achieve favorable outcomes.

Concurrent Review - While 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 one business day of the admission (unless the member is unable to do so) 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, Anthem 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 preauthorized, 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 available, Anthem will not pay.

Ongoing Care Needs

Ongoing care is coordinated through services such as utilization management, care management and disease management.

Utilization Management - Utilization management is used to determine if a service is medically necessary, delivered in the right setting and for the appropriate length of time. Care is compared to nationally recognized guidelines. This review may be used to determine payment for covered services. However, the decision for treatment is solely between the member and provider regardless of Anthem's decision made regarding reimbursement.

About Your Health Coverage

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 has discretion as to which members it offers care management. Anthem may not offer care management to all members with similar conditions.

Anthem's care management program is tailored to the individual. In certain extraordinary circumstances involving intensive care management, Anthem may, at its sole discretion, provide benefits for alternate care that are not listed as covered services. Anthem may also extend covered services beyond the contractual benefit limits of this coverage. 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 to provide the same benefits again to that member or to any other member. Anthem 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 who have been diagnosed with chronic illnesses, such as diabetes, heart disease and asthma.

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. 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.

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.

The PPO or participating provider agreement 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.

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 (888) 231-5046. Additional information about Anthem's disease management and wellness programs is available on Anthem's website at www.anthem.com.

Membership

Membership

Subscriber

The subscriber is the member in whose name the membership is established.

Dependents

A subscriber's dependents may include the following:

- **Legal spouse**
- **Common-law spouse.** The subscriber must submit a Common-Law Marriage Affidavit for the common-law spouse to be considered for enrollment. The Common-Law Marriage Affidavit may be obtained through Anthem's customer service department.
- **Domestic partner.** Anthem policy for eligibility allows for domestic partners.
- **Newborn child.** A newborn child born to the subscriber, the subscriber's spouse or the subscriber's domestic partner is covered under the subscriber's coverage for the first 31 days after birth without submitting and Enrollment Application/Change Form. If the mother of the newborn child is a dependent child of the subscriber, the newborn is not covered (see the heading **Grandchild** in this section).

During the first 31 day-period after birth, coverage for a newborn child shall consist of medically necessary care for injury and sickness, including care and treatment of medically diagnosed congenital defects and birth abnormalities, without regard to the limitations and exclusions applicable to other conditions or procedures covered by Anthem. All services provided during the first 31 days of coverage 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 the newborn child's participation in the coverage beyond the 31-day period after the newborn child's birth, a subscriber who has a non-family policy must complete and submit an Enrollment Application/Change Form to add the newborn child as a dependent child to the subscriber's policy. Anthem must receive the Enrollment Application/Change Form within 31 days after the birth of the child to continue coverage for the 32nd day and thereafter. Subscribers do **not** need to complete an Enrollment Application/Change Form to add the newborn child as long as they had family coverage that requires no additional premium at the time of birth of the newborn child.

- **Adopted child.** An unmarried child (who has not attained 18 years of age) adopted while the subscriber, the subscriber's spouse or the subscriber's domestic partner is eligible for coverage 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 coverage beyond the 31-day period after the adopted child's placement, the subscriber must complete and submit an Enrollment Application/Change Form to add the adopted child as a dependent child to the subscriber's policy. Anthem must receive the Enrollment Application/Change Form within 31 days after the placement of the child to continue coverage for the 32nd day and thereafter.

- **Dependent child.** An unmarried child (including a stepchild or a disabled child) under 19 years of age can be covered under the terms of this certificate. If the subscriber, the subscriber's spouse or the subscriber's domestic partner is subject to a qualified medical child support order for a dependent child of the subscriber, the subscriber's spouse or the subscriber's domestic partner, the dependent child is eligible for coverage, whether the child lives with the subscriber, the subscriber's spouse or the subscriber's domestic partner.

Membership

- **Overage dependent child.** An unmarried child age 19 through age 24 who is financially dependent on the parent or has the same legal residence as the parent may be covered under the terms of this certificate. At the end of the birth month of the limiting age, the child is automatically removed from the coverage as a dependent. Subject to the limitations below, we may require substantiating documentation of financial dependency (e.g., a current school class schedule, and proof of registration, proof of tuition payment or residential status) for an overage dependent to continue coverage. A completed Overage Dependent Enrollment Request Form and substantiating documentation must be submitted annually for coverage of the overage dependent child to continue. You may obtain an Overage Dependent Enrollment Request Form from Anthem's customer service department or by visiting our website at anthem.com. A dependent child who is no longer eligible for coverage may be eligible for continuation coverage.

College Student Medical Leave

We will extend coverage for up to one year when a college student otherwise would lose eligibility, if a child takes a medically necessary leave of absence from a postsecondary educational institution. Coverage will continue for up to one year of leave, unless dependent coverage ends earlier under another plan provision, such as the child's age exceeding our limit.

Medically necessary change in student status

Extended coverage is available if a college student would otherwise lose coverage because a serious illness or injury requires a medically necessary leave of absence or change in enrollment status (for example, a switch from full-time to part-time students status). We may request written certification from the child's physician confirming the serious illness or injury and the medical necessity of the leave or change in status.

Coverage continues even if the plan changes

Dependent coverage will continue during the leave as if the child had maintained student eligibility. This requirement applies even if a plan changes during the extended period of coverage.

- **Disabled dependent child.** An unmarried child who is 19 years of age or older, medically certified as disabled, and dependent on the parent can be covered under the terms of this certificate. Anthem must receive notice of the disability for the disabled dependent to continue coverage. A completed Mentally or Physically Disabled Dependent Form must be submitted for the disabled dependent to be eligible for coverage. 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.
- **Grandchild.** A grandchild of a subscriber, the subscriber's spouse or the subscriber's domestic partner is not eligible for coverage unless the subscriber, the subscriber's spouse or the subscriber's domestic partner is the court-appointed permanent guardian of the grandchild. The subscriber must submit an Enrollment/Application Change Form and evidence of court appointment as permanent guardian. Another option is to enroll the grandchild under an individual membership, subject to its terms and conditions.

Membership

Medicare-Eligible Members

NON-DUPLICATION OF MEDICARE

Anthem will not provide benefits that duplicate any benefits the member would be entitled to receive under Medicare. This exclusion applies to all Parts of Medicare in which the member can enroll without paying additional premium. However, if the member has to pay an additional premium to enroll in Part A, B, C or D of Medicare this exclusion will apply to that particular Part of Medicare for which the member must pay only if the member has enrolled in that Part.

If the member has Medicare, the Medicare coverage will not affect the services covered under this Policy, except as follows:

1. The member's Medicare coverage will be applied first (primary) to any services covered by both Medicare and under this Policy.
2. If the member receives a service that is covered both by Medicare and under this Policy, Anthem's coverage will apply only to the Medicare deductibles, Coinsurance and other charges for Covered Services that the member must pay over and above what's payable by any Medicare coverage.
3. For a particular claim, the combination of Medicare benefits and the benefits Anthem will provide under this Policy for that claim will not be more than the allowed Maximum Benefit Allowance the member has incurred for the Covered Services received.

Anthem will apply any expenses paid by Medicare for services covered under this Policy toward the member's Deductible.

The subscriber who is Medicare disabled and/or 65 years of age or older may apply for an Anthem Plan which supplements Medicare benefits. **SERVICES, BENEFITS AND PREMIUMS UNDER A MEDICARE SUPPLEMENT PLAN WILL NOT BE THE SAME AS THOSE PROVIDED UNDER THIS POLICY.**

Enrollment Process

In order for eligible applicants and their eligible dependents to obtain coverage, the applicant must follow Anthem's enrollment process, which details who is eligible for enrollment and what forms are required for enrollment. Coverage under this certificate begins as of the effective date stated on the health benefit ID card. No services received prior to that date are covered.

Note: Submission of an Enrollment Application/Change Form does not guarantee member enrollment.

Pre-existing Conditions

With any enrollment, eligible applicants and their dependents may be subject to a pre-existing condition limitation period as described in the **GENERAL EXCLUSIONS** section of this certificate. If a member has a pre-existing condition, Anthem will not pay the charges for any services related to the pre-existing condition during the limitation period. Anthem reserves the right to review member medical information if a pre-existing condition is thought to be present. A pre-existing condition limitation period may be retroactively added if such a pre-existing condition exists.

Enrollment Forms

The subscriber must submit an Enrollment Application/Change Form to add any dependents as members. Additional forms may be required for special dependent status. Subscribers may obtain an Enrollment Application/Change Form or any additional forms from Anthem's customer service department.

If a member terminates health insurance coverage with Anthem, and within the same year enrolls in a like-benefit coverage with Anthem, all covered benefits that have a benefit maximum will be carried into the new coverage. For example, if a benefit has a limit of one visit per year and the member received that benefit under the prior coverage, that member is not eligible under the new coverage for the same benefit, as benefits have been exhausted for that year.

Membership

Newly Eligible Dependent Enrollment

A current subscriber of this coverage may add a dependent that becomes newly eligible due to a qualifying event. Qualifying events include marriage, birth, and placement for adoption or issuance of a court order. Anthem must receive an Enrollment Application/Change Form for the addition of the dependent within 31 days after the date of the qualifying event. Proof of the qualifying event, e.g. a copy of the marriage certificate or court order, must be attached to the completed Enrollment Application/Change Form. Coverage will be effective on the date of the qualifying event.

When the subscriber, the subscriber's spouse or the subscriber's domestic partner 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 31 days of the issuance of such order. Anthem must receive a copy of the court or administrative order with the Enrollment Application/Change Form.

Multiple Anthem Coverages

If a member is covered under this certificate and is also covered by another Anthem individual policy, the member is limited to the one policy elected by the member, the member's beneficiary or the member's estate, as the case may be, and Anthem will return all premiums paid for all other such policies. However, Anthem will deduct any benefits paid under the individual policy from the subscription charges being refunded.

How to Change Coverage

Members are permitted to upgrade their coverage once in a calendar year by completing an Enrollment Application/Change Form and Health Statement. If Anthem approves the upgrade, the upgrade in coverage will become effective on the first of the month following Anthem's approval of the Enrollment Application/Change Form.

A member may downgrade existing coverage at any time by completing an Enrollment Application/Change Form or by contacting Anthem. The change will be effective on:

- The first of the month following our receipt of the Enrollment Application/Change Form.
- The paid-to date if the member is not paid to the next premium due date.

Termination

Active Policy Termination

This Policy will terminate upon failure to pay premiums when due. A grace period of thirty-one (31) days will be allowed for the payment of premiums. If the premiums are not paid within this thirty-one (31) day grace period, termination will be retroactive to the last date of the period for which premium has been paid. Anthem will not pay for any services provided on or after the date of termination. Any claims paid for services incurred after termination will be retroactively adjusted, unless prohibited by applicable law. If Anthem is obligated to pay for claims incurred after the termination date, the subscriber shall remain liable for a pro-rata premium through the latest date such claims were incurred.

Member coverage under this Policy ends:

- When your premium is not paid within the grace period. The grace period for payment of future premiums is thirty-one (31) days. If the premiums are not paid within this thirty-one (31) day grace period, termination will be retroactive to the last date of the period for which premium has been paid. If this Policy is terminated for non-payment of premiums, your Policy may, at our discretion, be reinstated. You will be required to submit a new Enrollment Application/Change Form and any premiums and/or fees that are owed in addition to a \$50 reinstatement fee, and you will be subject to medical underwriting. See the section Reinstatement in the PART called ADMINISTRATIVE INFORMATION for the reinstatement provision.
- Upon the subscriber's death.
- When the required premium has not been paid.
- When the member has committed fraud or intentional misrepresentation of material fact. Misrepresentation or omissions on the application may result in termination or rescission of this Policy.

Membership

This Policy may also be terminated if the member knowingly participates in or permits fraud or deception by any provider, vendor or any other person associated with this Policy. Termination for fraud or intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission.

- When the member has committed fraud or deception in the submission of claims or use of services or facilities or if you knowingly permit such fraud or deception by another. Termination is effective on the date of mailing the written notice.
- Upon becoming enrolled under any other Anthem Blue Cross and Blue Shield and/or Anthem non-group Policy or when You fail to cancel any other non-group coverage upon becoming enrolled under this Policy.
- At the first of the month following advance written notice to Anthem to cancel coverage. Coverage will be cancelled effective as of the first of the month following Anthem's receipt of the notice to cancel. Anthem will credit membership premium paid in advance on behalf of canceled members, unless Anthem does not receive the cancellation request at least 31 days prior to the effective date of the cancellation. Submit your written request to cancel to Anthem Blue Cross Blue Shield Attn: Membership, P.O. Box 9051 Oxnard, CA 93031-9051 or you may fax your request to: (303) 764-7282.
- When the subscriber establishes permanent residence outside of Colorado.
- When Anthem elects not to renew all of our individual health benefit coverages delivered or issued for delivery in this state. In such case, Anthem shall provide notice of the decision not to renew coverage to all affected individuals and to the Insurance Commissioner in each state in which an affected individual is known to reside at least 180 days prior to Anthem's non-renewal of the health benefit coverage.
- When the Insurance Commissioner finds that the continuation of the coverage would not be in the best interest of the member or the coverage is obsolete or would impair Anthem's ability to meet its contractual obligations. In such instance, Anthem shall provide notice of such discontinuance to each covered member at least 90 days prior to the date of discontinuance and shall provide each affected member the opportunity to purchase any other individual health coverage offered by Anthem without regard to the health status of the member.
- When Anthem ceases operations. Anthem will be obligated for services for the rest of the period for which premiums were already paid.

Dependent Coverage Termination

To remove a dependent from coverage, the subscriber must notify Anthem in writing within 31 days prior to the effective date of the change. If the change is received after the requested effective date, the change will be made effective the date Anthem is notified of the change. Anthem reserves the right to recoup any benefit payments made beyond the termination date.

Anthem will credit membership premium paid in advance on behalf of the terminated dependent unless Anthem does not receive the notification within 31 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.

Coverage for a dependent ends on the last day of the month immediately preceding the next monthly premium due date following receipt of the request or on the first occurrence of one of the following events:

- When the subscriber notifies Anthem to end coverage for a dependent.
- When the dependent child marries or no longer qualifies as a dependent by definition.
- On the date of a final divorce decree or legal separation for a dependent spouse, or upon termination of a domestic partnership.
- At the end of the month when legal custody of a child placed for adoption is terminated.

Membership

Certificate of Creditable Coverage

When a member's coverage with Anthem terminates, Anthem will send the subscriber a Certificate of Creditable Coverage, which will identify the length of the member's creditable coverage with Anthem. The member may need this letter as proof of prior coverage when the member enrolls with another coverage.

What Anthem Will Pay for After Termination

Except as provided below, Anthem will not pay for any services provided after the member's coverage ends even if preauthorization was received, unless eligibility was verified by the provider within two business days prior to each service received. Benefits cease on the date the member's coverage ends as described above. A member may be liable for benefit payments made by Anthem on behalf of the member for services provided after the member's coverage has terminated, even if the termination was retroactive.

When a member's coverage is terminated for any reason other than for non-payment of premium, fraud or abuse, Anthem shall provide for continued care of the member being treated at an inpatient facility, until the member is discharged or transferred to another level of care, subject to the terms of this certificate. The discharge date is considered the first date on which the member is discharged from the facility or transferred to another level of care. When coverage has been terminated and a member receives additional facility care after the discharge date, Anthem will not cover additional services received.

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 certificate as determined by Anthem and obtained in the manner required by this certificate. 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 service to be sure that preauthorization has been obtained by the ordering provider.

Anthem bases its decisions about preauthorization, 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 certificate including those in the **GENERAL EXCLUSIONS** section. All covered services are subject to the other conditions and limitations of this certificate.

Preventive Care Services

This section describes covered services and exclusions for preventive care.

Routine Exams and Immunizations

- Routine or periodic exams, e.g., pelvic exams. Exams are covered according to the frequency determined by the member's provider. Having the right exams at the right times may help you avoid serious illness. Check with the provider for specific health guidelines based on the member's age, sex and family history.
- Family history, current health problems and lifestyle all affect your risk for disease. The member should talk to their provider to determine if they are at high risk for specific diseases and then together determine the appropriate exam schedule.
- Preventive services and routine immunizations (including those required for school) immunizations protect the member from certain diseases and help prevent epidemics. While immunization risks to member's health are low, the risks from disease are high. Both children and adults need immunizations to help keep them healthy. Check with the provider about the immunization schedules recommended for children and adults.
- Child Health Supervision Services (including limited smoking cessation services) for Dependent children up to age 13, but only to the extent required by applicable law.
- Annual medical diabetes eye exams, or in accordance with the frequency determined by the member's provider.
- Routine hearing and vision screenings.

Routine/Preventive Diagnostic Services

- One routine screening mammogram is covered per members benefit year, regardless of age, or in accordance with the frequency determined by the member's provider. Non-routine mammogram exams are not part of the Preventive Care Services section and are subject to the provision of the Physician Office Services section.
- Routine cytological screening (pap test) regardless of age in accordance with the frequency determined by the member's provider.
- One routine prostate specific antigen (PSA) blood test and digital rectal examination per members benefit year, regardless of age, or in accordance with the frequency determined by the member's provider. Non-routine prostate exams are not part of the Preventive Care Services section and are subject to the provision of the Physician Office Services section.

Member Benefits

- Colorectal cancer screening coverage for the early detection of colorectal cancer and adenomatous polyps in accordance with the "A" and "B" recommendations of the U.S. Preventive Services Task Force. Colorectal cancer screening shall also be provided to members who are at a high risk for colorectal cancer, including members who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, ulcerative colitis; or other predisposing factors as determined by the member's treating physician.
- Routine PKU tests for newborns.
- Early Intervention Services for a member up to age 3, but only to the extent required by applicable law. In its sole and absolute discretion, Anthem may provide such benefits to an early intervention service broker, qualified early intervention service provider, any authorized governmental department in trust, or as otherwise permitted by applicable law or regulation.
- Immunizations against cervical cancer, to the extent recommended by the advisory committee on immunization practices of the U.S. Department of Health and Human Services.
- Influenza vaccinations and pneumococcal vaccinations according to the Center for Disease Control's Advisory Committee on Immunization Practices immunization schedule.
- Alcohol misuse screening and behavioral counseling interventions by outpatient primary care providers
- Tobacco use screening of adults and tobacco cessation interventions by outpatient primary providers.
- One Tetanus/Diphtheria vaccination every ten years.
- One prostate cancer screening every members benefit year. Non-routine prostate exams are not part of the Preventive Care Services section and are subject to the provision of the Physician Office Services section.
- Screening for lipid disorders if at an increased risk for coronary heart disease in accordance with the "A" or "B" Recommendations of the U.S. Preventive Services Task Force.

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

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

- Routine exams related to sports, insurance, school, church or camp.
- Routine care received in the emergency room.
- Immunizations for travel.

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:

- 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.
- Prescription birth control pills.
- Surgical sterilization (e.g., tubal ligation or vasectomy) and related services.

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).
- Reversals of sterilization.

Member Benefits

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 vasdeferens).

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.

Complications of Pregnancy and Newborn Care

Maternity and obstetrical care are not covered benefits regardless of where such services are received.

Complications of pregnancy are covered and include:

- Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity.
- Non-elective cesarean section, ectopic pregnancy, and spontaneous termination of pregnancy, which occurs during the period of gestation in which a viable birth is not possible.

For covered newborns all medically necessary care and treatment of injury and sickness is covered for the first 31 days of life. This includes medically diagnosed congenital defects and birth abnormalities during the mother's normal hospital stay including physician services for the newborn.

The newborn child must be the child of the subscriber, the subscriber's spouse or the subscriber's domestic partner to be eligible for coverage. If the mother of the newborn child is a covered dependent child of the subscriber, only the mother's services are covered benefits and any services the newborn child receives are not covered benefits. To learn how to enroll the newborn child of a dependent child, see the **DEPENDENTS** heading in the **MEMBERSHIP** section for information.

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

- Non-emergency or scheduled cesarean section.
- Services for false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
- 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. Replacement of pumps that are out of warranty and are malfunctioning and cannot be refurbished would be covered. In situations where new models or upgrades to the latest insulin pump are available, coverage would not be available. When diabetic supplies are provided by a pharmacy, they are covered as any other medical services, subject to the same deductible, coinsurance and out-of-pocket maximum as any other service.

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 professional provider.

For preventive care refer to the PREVENTIVE CARE SERVICES in this section. For family planning services, including maternity care, refer to the FAMILY PLANNING in this section. For diabetes treatment refer to the DIABETES MANAGEMENT in this section. Refer to the section entitled MENTAL HEALTH AND SUBSTANCE ABUSE CARE for those services covered by Anthem. To receive office services after hours, see the EMERGENCY CARE AND URGENT CARE section for information. Office visits may include administration of injections. Specialty Pharmacy Drugs used for these injections must be received from Our Specialty Pharmacy and listed on Anthem's Specialty Drug List to be covered. See the **Specialty Pharmacy** section for more information.

Not all covered services provided through the physician's office will be included in, or paid at the same level as, an office visit. Please see the **GLOSSARY** section for those services included in an office visit and see the *Health Benefit Plan Description Form* for cost sharing requirements.

Office Visits

See the *Health Benefit Plan Description Form* for member cost sharing for office visits. See the **GLOSSARY** section for the definition of office visit.

Professional Services

Professional services are services provided during a physician office-based visit that are different than those described in the definition of office visit (see the **GLOSSARY** section for definition). Professional services can be provided during the office visit by a physician or other professional provider. See the *Health Benefit Plan Description Form* for member cost sharing for services other than office visits.

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. 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. 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 coverage for an external prosthesis. Office-based surgical services are subject to preauthorization guidelines. See the MANAGED CARE FEATURES heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization guidelines.

Member Benefits

Benefits are provided in a physician's office for diagnostic services when required to diagnose or monitor a symptom, disease or condition including, but are 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* section for information.
- Allergy tests and treatment.
- Audiometric (hearing) and vision tests required for the diagnosis and/or treatment of an accidental injury or an illness.
- Injectable medications which require administration by a physician or other professional provider. For self injectable medications please see the prescription drug coverage section for information.

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

- Expenses for obtaining medical reports or transfer of files.
- 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 and vision 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 scans.
- Self-injectable drugs purchased through or provided by a physicians office.

Inpatient Facility Services

This section describes covered services and exclusions for acute inpatient care such as hospital, skilled nursing care facility (SNF), 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 preauthorization or unscheduled admission notification guidelines.** See the MANAGED CARE FEATURES heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization guidelines.

Refer to the section entitled MENTAL HEALTH AND SUBSTANCE ABUSE CARE for those services covered by Anthem, including acute medical detoxification. For accident or emergency medical care refer to the EMERGENCY CARE AND URGENT CARE section. For dental services refer to the heading DENTAL RELATED SERVICES for those services covered by Anthem.

Skilled Nursing Care Facility (SNF)

When We preauthorize skilled nursing care, benefits are available as specified up to a maximum number of days per calendar year as listed on the *Health Plan Description Form*. Preauthorization by Us for admission and for continued stay is required. See the **MANAGED CARE FEATURES** heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on Preauthorization guidelines.

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.

Member Benefits

- 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 allowed up to the maximum days as listed on the *Health Benefit Plan Description Form* per calendar 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, the following 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. Blood and blood plasma is covered.

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 the medical conditions while in the inpatient facility.
- Surgical services and reconstructive surgery. The surgical fee includes normal post-operative care.
- Anesthesia, 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 period of 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.
- 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 bariatric 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 coverage for an external prosthesis.
- For silicone breast implants benefits are provided for the removal of the implant, implants removed will not be replaced.
- Bariatric surgery and complications from bariatric surgery that satisfy Anthem's medical policy and which are received from a designated facility are covered benefits.

Breast reduction surgery (reduction mammoplasty) performed as a result of breast cancer, and services related to breast reduction surgery performed as a result of breast cancer, are covered.

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 preauthorization guidelines.

Inpatient Facility Services Exclusions — The following services, supplies or care are not covered:

- Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests or x-rays which could have been performed safely on an outpatient basis.
- 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, charges related to the non-compliance of medically necessary care are not eligible for coverage.
- 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 non-compliance 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, medications, 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 preauthorization guidelines. See the MANAGED CARE FEATURES heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization guidelines.

Outpatient Services may include administration of injections. Specialty Pharmacy Drugs used for these injections must be received from Our Specialty Pharmacy and listed on Anthem's Specialty Drug List to be covered. See the **Specialty Pharmacy** section for more information.

Refer to the section entitled 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 the section entitled DENTAL RELATED SERVICES 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.

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 example 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.
- Dialysis treatment.
- Respiratory therapy.
- Charges for processing, transportation, handling and administration of blood. Blood and blood plasma is covered.

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, anesthesia supplies and services for a covered surgery. See Anthem's medical policy at www.anthem.com for definitions of cosmetic services.
- 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.
- 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 coverage for an external prosthesis.

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 non-compliance 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.
- Any services or care for the treatment of sexual dysfunction.
- Sex change operations, medications, 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 scan.

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 and permanent dysfunction of any 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 member's health.

Anthem covers emergency services necessary to screen and stabilize a member without preauthorization 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 network provider or non-network provider. No prior authorization is necessary. A member should call 9-1-1 in the case of a life or limb-threatening emergency.

When a member is admitted to a facility following emergency care **Anthem must be contacted within one business day 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. See the *Health Benefit Plan Description Form* for member cost sharing for office visits and services other than office visits and the definition of office visit.

Member Benefits

BlueCard Access

When the member is temporarily away from the Anthem service area and needs urgent or after-hours medical care, the member can follow the steps outlined below:

- If a life or limb-threatening emergency, call 9-1-1 or go to the nearest medical facility.
- To find the nearest urgent care facility, the member may call the BlueCard program to find the name and addresses of nearby PPO doctors and hospitals or urgent care facility by calling the phone number listed on the member's health benefit ID card or by using the BlueCard doctor and hospital finder website at www.BCBS.com.
- If the member is unable to contact the BlueCard program, the member should go to the nearest medical facility.
- The BlueCard program will inform the member whether there is a PPO provider in the area. When the member arrives at the PPO doctor's office, hospital, or urgent care facility, simply present the member health benefit ID card.
- If the member uses a BlueCard provider, the member pays the appropriate payment to the BlueCard provider based on that provider's contract with the local Blue plan as well as the terms of this certificate. If the member does not use a BlueCard provider, the member pays the entire cost of care and will need to submit a claim to Anthem. Anthem will then reimburse the member based on the maximum benefit allowance, less applicable deductible, copayment and/or coinsurance.

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. 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 customer service. 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 of 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:

- Non-emergency continued care after the member's condition has stabilized.

Ambulance and Transportation Services

This section describes covered services and exclusions for services provided during an ambulance trip. Benefits are provided for supplies, services and 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 member's 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 services, which must have the necessary patient care equipment and supplies to address the needs of the patient, are 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. Anthem will take into account whether the patient's condition must be such that any form of transportation other than by ambulance would be medically contraindicated or the patient's location is such that accessibility is only feasible by air or water transportation.

Member Benefits

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 deductible and coinsurance will still apply. Please refer to the *Health Benefit Plan Description Form* for maximum payment information.

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.

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.

From the member's third birthday until the member's sixth birthday, benefits are allowed up to the maximum visits as listed on the *Health Benefit Plan Description Form*, or 20 visits each, whichever is greater, per year for physical, speech and occupational therapies. Benefits are for the care and treatment of congenital defects and birth abnormalities for covered children without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. From the member's birth until the member's third birthday, these benefits shall be provided only where and only to the extent required by applicable law.

For all other members (e.g. those 6 and older, or who do not qualify for the benefits above), benefits are provided for physical and occupational therapies from a licensed therapist. The therapy must be medically necessary and the expectation must exist that the therapy will result in a practical improvement within a reasonable period of time. Benefits for speech therapy are allowed up to the maximum visits as listed on the *Health Benefit Plan Description Form* for treatment of a medical condition per calendar year.

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 members from the age of 6 years and older will reduce the number of speech therapy visits allowed.

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 are allowed and the program must start within three months of the major cardiac event and be completed within six months of the major cardiac event.

Member Benefits

- Chiropractic benefits are allowed for services administered by a chiropractor who acts within the scope of their license for the chiropractic treatment of an illness or accidental injury. Chiropractic benefits are limited to office visits for manual manipulation of the spine, X-ray of the spine and certain physical modalities and procedures.

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

- Home programs for on-going conditioning and maintenance.
- Therapies for learning disorders, behavioral or personality disorders, therapies (including but not limited to speech therapy) for dysfunctions that are self-correcting such as language therapy for young children with natural dysfluency or developmental articulation errors that are self-correcting, 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.
- Membership at health spas or fitness centers.
- 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).

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 skilled nursing services, home health aide services and other therapeutic related services in the home setting. 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 preauthorize all services and reserves the right to review treatment plans at periodic intervals.

Covered services include the following and are allowed up to the maximum visits as listed on the *Health Benefit Plan Description Form* per calendar year:

- Professional nursing services performed by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N).
- Certified Nurse Aide services under the supervision of a Registered Nurse or 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.

Member Benefits

- Medical/social services.
- Medical supplies (including respiratory supplies), durable medical equipment (rental or purchase), oxygen, appliances, prostheses and orthopedic appliances.
- Intravenous medications and other prescriptions drugs ordinarily not available through a retail pharmacy.
- Nutritional counseling by a nutritionist or dietitian.
- Specialty Pharmacy Drugs listed on Anthem's Specialty Drug List must be obtained through Anthem's Specialty Pharmacy. See the **Specialty Pharmacy** section for more information.

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 section entitled MENTAL HEALTH AND SUBSTANCE ABUSE CARE 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.

Infusion Therapy

If services are performed in the home, those services must be billed by and performed by a provider licensed by state and local laws.

A **Course of Therapy** is defined as Physician prescribed Infusion Therapy for a period of ninety (90) days or less.

Covered Services include:

- Drugs and other substances used in Infusion Therapy.
- Professional services to order, prepare, dispense, deliver, administer, train or monitor, including clinical Pharmacy support and any Drugs or other substances used in a Course of Therapy.
- All necessary durable, reusable supplies and durable medical equipment including, but not limited to, pump, pole and electric monitor.
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products.

Infusion Therapy Exclusions— The following services, supplies or care are not covered:

- Compounding fees such as charges for mixing or diluting Drugs, medicines or solutions or incidental supplies including disposable items such as cotton swabs, tubing, syringes and needles for Drugs, adhesive bandages and intravenous starter kits.
- Drugs and medicines not requiring a Prescription.
- Drugs labeled "Caution, limited by federal law to investigational use" or drugs prescribed for experimental use.
- Drugs or other substances obtained outside the United States for use within the United States.
- Non-FDA approved homeopathic medications or other herbal medications.
- Charges by a Non-Participating Provider exceeding the Average Wholesale Price of a Drug as determined by the manufacturer. The Average Wholesale Price includes the preparation of the finished product.

Note: Medical Supplies and Equipment used in Infusion Therapy will not be reimbursed under any other benefit of this Policy.

Member Benefits

Hospice Care

This section describes covered services and exclusions for hospice care. 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. Please refer to the *Health Benefit Plan Description Form* for maximum payment information.

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 conditions will be subject to the certificate provisions that apply to other illness or injuries.

Covered services are allowed include the following services:

- Intermittent and 24 hour on-call professional services provided by or under the supervision of a Registered Nurse.
- Intermittent and 24 hour on-call social/counseling services.
- Certified nurse aide services or nursing services delegated to other persons pursuant to applicable state law.
- Inpatient hospice care.
- Inpatient hospice respite care. Inpatient hospice respite care may be provided only on an intermittent, non-routine, short-term basis. It is limited to periods of five days or less up to two admissions per member's lifetime.
- Intravenous medications and other prescriptions drugs ordinarily not available through a retail pharmacy.
- Short-term inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management. Benefits are limited to a separate 30-day period.
- Diagnostic testing.
- Transportation.
- Medical supplies (including respiratory supplies), durable medical equipment (rental or purchase), oxygen, appliances, prostheses and orthopedic appliances.
- Bereavement support services for the covered family members during the twelve-month period following the death of the member.
- Physician services.
- Physical, occupational, speech and respiratory therapies.
- Nutritional counseling by a nutritionist or dietitian.

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

- Services of a mental health social worker. Refer to the section entitled MENTAL HEALTH AND SUBSTANCE ABUSE CARE 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.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement, or other legal services.

Human Organ and Tissue Transplant Services

This section covered services and exclusions for organ and tissue transplants. Anthem shall provide benefits for human organ and tissue transplant services only with preauthorization by Anthem. The hospital must be designated and approved by Anthem to perform specific covered services provided under this benefit. It should be noted that not every designated hospital performs each of the specified covered services. In addition, the member must follow all provisions in this benefit program.

Member Benefits

Benefits are provided for services directly related to the following transplants:

- Heart
- Lung (single or double)
- Heart-Lung
- Kidney
- Kidney-Pancreas
- Pancreas
- Liver
- Bone marrow transplantation performed in accordance with Anthem medical policy
- Peripheral Stem Cell procedures performed in accordance with Anthem's medical policy
- Cornea

A member is eligible for the covered services contained in this section if the following guidelines are met:

- To receive services at the in-network benefit level, all human organ and tissue transplants must be performed at a hospital designated and approved by Anthem for each specific covered service provided under this section.
- Anthem and the approved hospital must determine that a member is a candidate for any of the covered services specified in this section.
- All human organ and tissue transplants must be preauthorized based upon the clinical criteria and guidelines established, adopted or endorsed by Anthem or its designee in the sole discretion of Anthem. Approval for such covered services will be at the sole discretion of Anthem, subject to a member's right to appeal, as described in the **COMPLAINTS, APPEALS AND GRIEVANCES** section.
- All hospital admissions that are not a medical emergency are subject to preauthorization by Anthem.
- In the event that the services must be performed based on a medical emergency, Anthem must be notified within one business day after admission.

Members who are now eligible for, or who are anticipating receiving eligibility for Medicare benefits are solely responsible for contacting Medicare to determine if the transplant will be eligible for Medicare benefits.

The following are covered services as long as they are preauthorized:

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.

 Member Benefits

Surgical Covered Services

- Surgical covered services in connection with covered human organ and tissue transplants with preauthorization 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 surgical assistant in the performance 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.
- 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

- Medically necessary 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 the member's coverage has an outpatient prescription drug benefit.
- Transportation of donor organ or tissue.
- Evaluation and surgical removal of the donor organ or tissue and related supplies.

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

- When both the recipient and the donor are members of Anthem, 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 an Anthem member, and the recipient is not a covered Anthem member, benefits will not be provided for the donor or recipient expenses.

Covered Services related to the donor and/or donated organ or tissue, such as hospital, surgical, medical, storage and transportation costs are also covered. Benefits provided to the donor will be charged against the recipient member's coverage under this certificate for covered transplants.

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 coverage.

Member Benefits

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.
- Any travel, lodging or meal expenses for the member or family members.
- Services and supplies related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition that are in any way related to the artificial and/or mechanical heart or ventricular/atrial assist devices or the failure of those devices long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

Hearing Aid Services

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

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

1. Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be provided as part of Diagnostic Services.
2. Hearing aids as well as services and supplies including the initial assessment, fitting, adjustments and auditory training that is provided according to accepted professional standards. Initial and replacement hearing aids will be supplied every 5 years, unless alteration to the existing hearing aid is not adequately meeting the member's need. Hearing aids **not** will be provided as part of Durable Medical Equipment.

Medical Supplies and Equipment

This section describes covered 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 under the heading **DIABETES MANAGEMENT**. Supplies are subject to preauthorization guidelines. See the **MANAGED CARE FEATURES** heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization guidelines.

The supplies, equipment and appliances described in this section are a covered benefits based on Anthem medical policy. Benefits described in this section are allowed up to a maximum Anthem payment as described on the *Health Benefit Plan Description Form* per calendar year. Any services over the maximum Anthem payment are the member's responsibility

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 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 heading **PRESCRIPTION DRUGS** found in the **MEMBER BENEFITS** section.

Durable Medical Equipment

Durable medical equipment is used for a medical purpose, can withstand repeated use, generally is not useful to a person in the absence of an illness or injury and is appropriate for use in your home for activities of daily living purposes, including such things as crutches, wheelchairs, breathing equipment and hospital beds, are covered if medically necessary and prescribed by a physician for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are in accordance with generally accepted standards of medical practice. 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 Anthem. Other situations will be reviewed on a case by case basis. During repair or maintenance of durable medical equipment, Anthem will provide coverage for replacement rental equipment. Durable medical equipment used as part of an inpatient admission is covered as part of the inpatient hospital admission.

DME is not intended to be used for athletic or recreational activities as opposed to assisting the patient in the activities of daily living. DME which includes an additional feature or accessory, or is a non-standard or a deluxe item that is primarily for the comfort and convenience of the patient or is a duplicative piece of equipment intended to be used as a backup device, for traveling or for multiple residences are not covered.

Rental or purchase of durable medical equipment is payable if it meets the following conditions:

- Must be ordered by a physician.
- Must be of no further use when medical need ends.
- Must be usable only by the patient.
- Must be used primarily for medical purposes rather than for the patient's comfort or hygiene.
- Cannot be for environmental control.
- Cannot be for exercise.
- Must be manufactured specifically for medical use.
- Must be used by the patient for normal activities of daily living. Special equipment used for sports is not payable.

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. For prosthetic devices (arms and legs), benefits are at least equal to those benefits provided under federal law for health insurance for the aged and disabled, if applicable. Prosthetic devices shall not be considered Durable Medical Equipment.

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.
- Wigs with a physician's prescription, up to a separate maximum Anthem payment as listed on the *Health Benefit Plan Description Form* per calendar year.

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.
- 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.
- Orthotics (except for members with diabetes), whether functional or otherwise, regardless of the relief they provide.
- Home exercise and therapy equipment.
- Consumer beds or waterbeds.
- 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 describes covered services and exclusions for accident related dental services, anesthesia for children, inpatient services for dental related services, and cleft palate and cleft lip conditions, and temporomandibular joint care. Dental services are not covered under this certificate except under the specific circumstances described below. **This certificate provides coverage for medical conditions and should not be considered as the member's dental coverage.** All dental services and supplies are subject to preauthorization guidelines. See the MANAGED CARE FEATURES heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization 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.
- The first dental services must be performed within 90 days after your accident.
- Related services must be performed within one year after your accident. Services after one year are not covered even if coverage is still in effect.

Benefits for restorations are limited to those services, supplies, and appliances 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 is 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 to a degree that would require unconscious sedation.

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 provisions for the coverage of cleft palate and/or cleft lip as apply 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.

 Member Benefits

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.
- 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.

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 *Health Benefit Plan Description Form*. An in-network licensed therapist or home health agency must provide the nutrition services. All services must be preauthorized, see the MANAGED CARE FEATURES heading in the **ABOUT YOUR HEALTH COVERAGE** section for information on preauthorization 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 information can be found under the heading HOME HEALTH CARE/HOME IV THERAPY and HOSPICE CARE.

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.

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 calendar year when preauthorized 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

This section covers services and exclusions for mental health conditions and substance abuse care.

Mental health conditions described in this section are identified as a mental condition 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 care benefits are for acute medical detoxification and for substance abuse rehabilitation and counseling. 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 inpatient or outpatient basis for treatment that will assist the member to live without abusing alcohol or drugs. If the member is admitted for an unscheduled emergency admission, notification requirements can be found below under the "Preauthorizations" heading.

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. Inpatient services must be provided by a licensed hospital, psychiatric hospital, alcohol 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. If the member is admitted for an unscheduled emergency admission, notification requirements can be found below under Preauthorization/Precertifications.

Benefits are provided for medication management for mental health conditions by the member's medical provider, psychiatrist, or prescriptive nurse. If the medication management is provided by the member's medical provider benefits are covered under the medical benefit. If medication management is provided by a psychiatrist or a prescriptive nurse, benefits are paid under the mental health benefit.

Benefits are provided for Alcohol misuse screening, behavioral counseling interventions, tobacco use screening of adults and tobacco cessation interventions by outpatient primary care providers.

Preauthorizations/Precertifications

The member must contact Anthem's behavioral health administrator to determine medical necessity, appropriate treatment level and appropriate setting. Inpatient services are subject to preauthorization notification guidelines. See the MANAGED CARE FEATURES heading in the section entitled ABOUT YOUR HEALTH COVERAGE for information on preauthorization guidelines. When the member does not obtain prior approval from our behavioral health administrator and does not receive services from the provider designated by that approval, services are not covered.

Anthem's behavioral health administrator must be notified for all emergency admissions on the next business day of an admission occurring Sunday through Thursday. Anthem's behavioral health administrator must be notified for all emergency admissions occurring on Fridays, Saturdays, and/or holidays, by the next business day.

Member Benefits

Inpatient Services

Treatment for inpatient mental health and/or alcoholism conditions are limited to the number of days as listed on the *Health Benefit Plan Description Form*. Provider visits received during a covered admission are also 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

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. Every two partial day treatments count as one full inpatient day and will be applied against the member's maximum inpatient benefit. For the maximum number of partial hospitalization days, see the *Health Benefit Plan Description Form*.

Outpatient Services

The 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. Benefits are limited to a maximum benefit as described on the *Health Benefit Plan Description Form* per calendar year 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, outward bound programs, even if psychotherapy is included.
- Private room expenses.
- Biofeedback.
- 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.
- Custodial care.
- Domiciliary care.

Clinical Trials

This section discusses covered services and exclusions for clinical trials or clinical research.

Coverage is provided for routine patient care costs for covered members during a clinical trial if: **(All these conditions must be met)**

- The treating physician recommends participation in the clinical trial after determining that participation has the potential to provide therapeutic health benefit to the covered person;
- The clinical trial or study is approved under the September 19, 2000 Medicare national Coverage Decision regarding clinical trials;
- The treating provider is certified, registered, or licensed, practicing within the scope of his/her expertise and the facility and personnel providing the treatment are experienced and adept;
- Prior to participating in a clinical trial or study, the covered person has signed a consent indicating that they have been informed of the procedure, risks and coverage is in accordance with their benefit plan (including the application of out of network cost shares; and
- The covered person suffers from a condition that is disabling, progressive or life-threatening.

Clinical Trial Exclusions – The following services, supplies or care are not covered:

- Any portion of the clinical trial or study that is paid for by a government or biotechnical, pharmaceutical, or medical industry;
- Any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
- Expenses unrelated to participating in the clinical trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;
- An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;
- Costs for the management of research relating to the clinical trial or study;
- Coverage for any service or procedure related to the diagnosis, treatment or prevention of complications related to a clinical trial or study;
- Health care services that, except for the fact that they are being provided in a clinical trial are otherwise specifically excluded from coverage under the covered person's health plan; or
- Health care services or procedures related to the diagnosis, treatment or prevention of complications related to a clinical trial.

Retail Pharmacy/Mail Order Prescription Drugs

This section describes our outpatient pharmacy benefits for medications obtained through a retail or mail order pharmacy. **Prescription drug benefits cover only generic prescription drugs listed in the Anthem Generic Prescription Drug List/Formulary.**

Outpatient Pharmacy services do not include services received in the Hospital as an Inpatient a Medical Supply, durable medical equipment or appliance, or when provided by a Specialty Pharmacy. Refer to the **INPATIENT SERVICES** and **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES** sections for services covered by the Certificate. This section describes our outpatient pharmacy benefits for medications obtained through a retail or mail-order pharmacy. For medications or equipment obtained not through a pharmacy, see the **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES** section of this Certificate.

The Outpatient pharmacy benefits available under this certificate are managed by our Pharmacy benefits management company ("pharmacy affiliate"). As part of its services to Us, the pharmacy affiliate offers a nationwide network of retail pharmacies, a mail service pharmacy and clinical services.

For certain prescription drugs, the prescribing physician may be asked to provide additional information before We will determine Medical Necessity. We may, at our sole discretion, establish quantity limits for specific prescription drugs. The pharmacy affiliate, in consultation with Us also promotes and enforces the appropriate use of medications by reviewing for improper dosage, potential drug to drug interactions or drug-pregnancy interactions.

Member Benefits

Certain prescription drugs (or the prescribed quantity of a particular drug) may require Preauthorization. At the time you fill a prescription, the In-Network pharmacist is informed of the Preauthorization requirement through the pharmacy's computer system, and the pharmacist is instructed to contact the pharmacy affiliate. For a list of current drugs requiring Preauthorization, contact our customer service department at (888) 231-5046, or review the list on our website at www.anthem.com.

The Provider or In-Network pharmacist can check with Us to verify any quantity limits, Step Therapy requirements, Preauthorization requirements, or appropriate generic recognized under the Certificate.

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

Outpatient pharmacy benefits received from a In-Network pharmacy are limited to:

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

Each prescription is subject to a Copayment or Coinsurance. The Copayment and Coinsurance is based on the retail price charged for your prescription by our pharmacy affiliate or the pharmacy or mail order service that fills the prescription. If the prescription order includes more than one covered drug or supply, a separate copayment or coinsurance amount is required for each covered drug or supply. See the *Health Benefit Plan Description Form* for member cost sharing for each covered prescription and/or refill. The Copayment and Coinsurance will not be reduced by any discounts, rebates or other funds received by the pharmacy affiliate from drug manufactures, or similar vendors and/or funds received by Us from the pharmacy affiliate.

You are limited a 30-day supply of a prescription drug if obtained at a Pharmacy or up to a 90-day supply if received through Our In-Network mail order Pharmacy. For oral contraceptives, you are limited to one pill pack (normally 28 days) at an In-Network pharmacy, or three pill packs by mail order. When Medically Necessary, a one-month vacation override is available with applicable Deductible and Coinsurance if you are traveling out of our service area.

Members may need to pay for the full cost of the prescription and file their own claim if they obtain covered Prescription Drugs from an Out-of-Network Pharmacy. Each prescription order is subject to a Copayment or Coinsurance.

All prescription drugs must be on our Generic Prescription Drug List/Formulary to be eligible for benefits. Member cost sharing is described in the *Health Benefit Plan Description form*.

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

Mail Service Prescriptions .

You may also purchase your maintenance medication by utilizing our mail order pharmacy and have your prescription delivered directly to your home. To receive your maintenance medicine prescription by mail, follow these 3 steps:

- Ask your doctor to prescribe a 90-day supply of your maintenance medicine plus three refills (certain medicines will be subject to state or federal dispensing limitations). If you need the medicine immediately, ask your doctor for two prescriptions, one to be filled right away and another to be sent to the mail service pharmacy;
- Complete the order form which is enclosed within the mail service pharmacy envelope; and
- Mail your order form, written prescription(s), and a payment to cover the amount of your Coinsurance to the mail order service pharmacy affiliate. Credit card, debit card or check are acceptable.

You will receive your prescription drugs via first class mail or UPS approximately 14 days from the date you sent your order. Orders can be tracked on our website at www.anthem.com under MyHealth@Anthem.

Helpful Tip: We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at (800) 281-5524.

You will receive refill forms and a notice that shows the number of refills your doctor ordered in the package with your drugs. To order refills, you may use our website at www.anthem.com under MyHealth@Anthem or contact our customer service department to obtain the mailing address for the mail order service pharmacy affiliate.

When you may need to file a claim

You may need to file your own claim if:

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

We receive financial credits or rebates from drug manufacturers based on the total volume of claims processed for their products utilized by our Members. These credits are used to help stabilize rates. Reimbursements to pharmacies are not affected by these credits.

Prescription Drugs and Medicines Exclusions:

- Prescription drugs that are not listed on the Anthem Generic Prescription Drug List/Formulary.
- Prescription Drugs and supplies received as an inpatient in a Hospital or other covered inpatient facility, except where covered as part of the inpatient stay;
- 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 included but are not limited to Rogaine®, Viniqa®, and Tretinoin (sold under such brand names as Retin-A®);
- Any drug, product or technology within six (6) months of Food and Drug Administration (FDA) approval. We may, at our sole discretion, waive this exclusion in whole or in part for a specific new FDA approved drug product or technology;
- Any medications used to treat infertility;
- Delivery charges for prescriptions;
- 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 the **PRESCRIPTION DRUG** section (when applicable);
- Therapeutic devices or appliances, including support garments and other non-medicinal supplies (regardless of intended use);

Member Benefits

- Nonprescription and over-the-counter drugs, including herbal or homeopathic preparations, and Prescription Drugs that have over-the-counter bioequivalent even if written as a prescription;
- Prescription drugs that have clinically equivalent alternatives, even if written as a prescription. The member may request a copy of the list of drugs covered by calling Anthem's customer service department.
- 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 Us, at our sole discretion;
- Refills of prescriptions in excess of the quantity or refill frequency prescribed by the Provider, or refilled more than one year from the date prescribed;
- Prescription Drugs dispensed for the purpose of international travel;
- Prescription Drugs which have been obtained through a Home Health Agency;
- Replacement of lost or stolen Prescription Drugs.
- Medications received from an Out-of-Network pharmacy.

Specialty Pharmacy

The benefits of this section include Specialty Pharmacy Drugs listed on Anthem's Specialty Drug List. Specialty drugs are high-cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty drugs may require nursing services or special programs to encourage patient compliance. 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 Anthem's 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, if a Medical Supply, durable medical equipment or appliance. Refer to the **INPATIENT SERVICES** and **MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, AND APPLIANCES** sections for services covered by the Certificate. This section describes our 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, Retail Pharmacy or other specialty pharmacy unless you qualify for an exception.

The Outpatient Specialty Pharmacy benefits available under this Certificate are provided by Our Specialty Pharmacy Management affiliate. As part of its services to Us, the Specialty Pharmacy Management affiliate is a full service Specialty Pharmacy which ships medications to you by overnight mail or common carrier for up to a 30-day supply (you cannot pick up your medication from the Specialty Pharmacy Management affiliate). Our Specialty Pharmacy Management affiliate is not a Retail Pharmacy or a mail order service.

You may review the current Specialty Pharmacy Drug List on Our website at www.anthem.com. You may also request a copy of the Specialty Pharmacy Drug List by calling our customer service department. The Anthem Specialty Drug List is subject to periodic review and amendment. Inclusion of a drug or related item on Anthem's Specialty Drug List is not a guarantee of coverage.

Your Copayment/Coinsurance amount is based upon which tier the Specialty Pharmacy Drug falls under. A Specialty Pharmacy Drug must be a legend drug to be eligible for benefits. Please refer to the Health Benefit Plan Description Form for the copayment/coinsurance amounts.

We use a variety of administrative processes and tools, such as Preauthorization for health care services to help determine the most appropriate use and cost-effective compared to alternative interventions for the health care services available to Our Members. Certain Specialty Pharmacy Drugs may require Preauthorization. At the time you fill a prescription, you will be informed of the Preauthorization requirement. For a list of current drugs requiring Preauthorization, contact Our customer service department, or review the list on Our website at www.anthem.com. You can also check with Us to verify drug tier placement or Preauthorization requirements.

Member Benefits

Outpatient Specialty Pharmacy benefits include a therapeutic drug substitution program approved by Us and managed by the Specialty Pharmacy Management affiliate. This is a voluntary program designed to inform you and Physicians about alternatives to Specialty Pharmacy Drugs. The Specialty Pharmacy Management affiliate 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 Our Specialty Pharmacy Management affiliate 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 or physician office use, you will need to pay the appropriate Deductible, Copayment or Coinsurance 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.

You may also contact Our Specialty Pharmacy Management affiliate at:

Anthem Blue Cross and Blue Shield
 Attn. Specialty Pharmacy Program
 2825 Perimeter Road
 Indianapolis, IN 46241

Phone (800) 870-6419
 Fax (800) 824-2642

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 Our customer service department or at www.anthem.com.

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

1. Specialty Pharmacy Drugs which are not provided through the specialty program, including but not limited to Specialty Pharmacy drugs that are provided through a Physician's office or Home Health Agency.
2. When benefits are provided under the Specialty Pharmacy benefits they will not be provided under the Retail Pharmacy Prescription Drug section of this certificate.
3. 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.

General Exclusions

These general exclusions apply to all benefits described in this certificate. This coverage provides benefits for specific services described in this certificate 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 certificate.

If a service is not covered, then all services performed in conjunction with that service are not covered.

Anthem is the final authority for determining if services and supplies are medically necessary for the purpose of payment.

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

Acupuncture — This coverage does not cover services or supplies related to acupuncture care.

Alternative or complementary medicines — This coverage 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, bioenergetic synchronization technique (BEST), clonics or iridology.

Artificial conception — All services related to artificial conception are not covered.

Auto accident injuries — All services related to an auto accidents are not covered except as provided under the heading AUTOMOBILE INSURANCE PROVISIONS found in the **ADMINISTRATIVE INFORMATION** section.

Before effective date — This coverage does not cover any service received before the member's effective date of coverage.

Biofeedback — This coverage does not cover biofeedback and related services.

Breast reduction surgery — This coverage does not cover breast reduction surgery (reduction mammoplasty) or services related to breast reduction surgery, unless the breast reduction surgery is performed as a result of breast cancer.

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

Complications of non-covered services — This coverage 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.

Conditions that result while committing a crime, through civil disobedience or because of the release of nuclear energy. — This coverage does not cover any services or supplies provided as a result of injuries or conditions resulting from committing a crime, through civil disobedience or because of the release of nuclear energy.

Convalescent care — Except as otherwise specifically provided, this coverage 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 coverage does not cover services and supplies used primarily for the member's personal comfort or convenience. Such services and supplies include 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 coverage 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 — This coverage does not cover cosmetic procedures, services, equipment or supplies for psychiatric or psychological reasons, to change family characteristics, to improve appearance or to improve conditions caused by aging. Services required as a result of a complication or adverse outcome of a non-covered cosmetic service. For Anthem's medical policy on cosmetic services, see our website at www.anthem.com or call customer service.

Examples of cosmetic procedures are face lifts, botox injections, breast augmentation, rhinoplasty, or scar revisions.

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

Custodial care — This coverage 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 SERVICES.

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

Discharge against medical advice — This coverage 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 services related to a discharge day are not covered except as provided in the **MEMBER BENEFITS** section.

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

Duplicate (double) coverage — This coverage does not cover services and supplies already covered by other valid coverage.

Excess Amounts — This coverage does not cover any amounts in excess of the maximum amounts stated in the member benefit section of this Certificate.

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 preauthorized. 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.

General Exclusions

Foreign claims - This coverage does not cover claims incurred in a foreign country except claims for the initial treatment of a medical emergency or urgent condition.

Genetic testing/counseling — This coverage 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 preauthorization.

Government operated facility — This coverage 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.

Hearing — This coverage does not cover hearing aids or routine hearing tests, except as provided in the **MEMBER BENEFITS** section.

Health club memberships — This coverage does not cover 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.

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

Illegal conduct — This coverage does not cover services or supplies for illness or injuries resulting in 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 coverage 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 coverage does not cover services or supplies related to therapies for learning deficiencies and/or behavioral problems except as provided in the **MEMBER BENEFITS** section.

Maintenance therapy — This coverage does not cover any treatment that does not significantly enhance or increase the member's 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 coverage does not cover expenses for services and supplies that are not medically necessary. Services may be denied before or after payment unless preauthorization 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 coverage does not cover charges for the member's failure to keep scheduled appointments. The member is solely responsible for such charges.

Morbid obesity/Bariatric surgery — This coverage does not cover costs that exceed the aggregate lifetime maximum for bariatric surgery. For information about coverage, see the **MEMBER BENEFITS** section of your Anthem certificate, under the INPATIENT FACILITY SERVICES heading and the *Professional Services* subheading.

Neuropsychiatric testing — This coverage does not cover neuropsychiatric testing unless allowed by Anthem's medical policy.

General Exclusions

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

- Health spa or health fitness centers (whether or not services are provided by a licensed or registered provider).
- School infirmary.
- 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 a mutual benefit association, labor union, trustee, or any similar person or group.
- 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 coverage does not cover non-medical expenses, including but not limited to:

- Adoption expenses.
- After hours charges by physicians.
- Charges by physicians for completion of forms.
- Educational classes and supplies not provided by the member's provider unless specifically allowed as a benefit under this certificate.
- Vocational training services and supplies.
- Mailing and/or shipping and handling expenses.
- Interest expenses, administrative fees 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/purifiers, 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.

Nutritional and/or dietary supplements — This coverage does not cover nutritional and/or dietary supplements, except as provided in this certificate 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 coverage 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 coverage 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 coverage 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 coverage is terminated except as provided in the **MEMEBERSHIP** section.

General Exclusions

Pre-existing conditions — A pre-existing condition is any injury, sickness, pregnancy, or any condition related thereto for which the member has, during the twelve consecutive months immediately preceding the member's effective date of membership, either:

- Incurred charges;
- Received medical treatment;
- Consulted a health care professional;
- Taken prescription drugs.

Anthem will not pay for services related to a pre-existing condition for twelve consecutive months after the member's effective date of membership, unless the member had continuous prior coverage and no lapse in coverage of more than 90 days prior to enrollment. The member will receive credit against the twelve-month preexisting condition limitation period for each day of prior coverage. The member may contact Anthem's Customer Service department for additional information on how this may apply to the member.

NOTE: A newborn child, adopted child, or child placed for adoption is not subject to pre-existing conditions exclusion if enrolled within 31 days of eligibility.

Qualifying previous coverage means coverage provided through Medicare, Medicaid, employer-based coverage, group health insurance, or a health benefit plan. It also means one or more individual health insurance policies, including health maintenance organization coverage, Cover Colorado, or prepaid hospital or medical care coverage, provided they were in effect for a period of at least one year. If coverage was provided by an individual policy, it did not need to provide coverage for maternity or mental health care.

Pregnancy — This coverage does not cover services related to normal pregnancy including prenatal and deliver services. For complications of pregnancy, see **MEMBER BENEFITS**, under FAMILY PLANNING. See the **DEPENDENTS** heading in the **MEMBERHIP** section for information about enrolling a newborn.

Private duty nursing services — This coverage does not cover private duty nursing services.

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

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

Radiology services — This coverage does not cover Ultrafast CT scan and peripheral bone density testing. This coverage does not cover the following except as described by medical policy screening or as provided in this certificate, whole body CT scan or routine screening.

Report preparations — This coverage 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.

Reversal of sterilization — This coverage does not cover services to reverse voluntarily induced sterility,

Self-inflicted injuries — This coverage does not cover services or supplies necessitated by injuries which a member intentionally self inflicted., except where the law prohibits such an exclusion

Services for which the member has no legal obligation to pay (free services) — This coverage does not cover services for which the member is not legally obligated to pay or for which no charge would be made if the member did not have a health plan or insurance coverage.

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

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

Smoking cessation — This coverage does not cover smoking cessation programs, products, hypnosis, supplies or devices to quit smoking, except as required by Colorado law.

General Exclusions

Surrogate mother services — This coverage does not cover any services or supplies provided to a person not covered under this certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Taxes — This coverage does not cover sales, service, or other taxes imposed by law that apply to benefits covered under this certificate.

Temporomandibular joint surgery or therapy — This coverage 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 coverage does not cover travel or lodging expenses for the member, member's family or the Physician except as provided under HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES heading in the **MEMBER BENEFITS** section.

Vision — This health coverage does not cover any routine eye examinations, routine refractive examinations, eyeglasses, frames, 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 coverage 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 coverage 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 coverage 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 coverage does not cover weight loss programs whether or not they are pursued under medical or physician supervision. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

Workers' compensation — This plan does not cover services and supplies for a work related accident or illness, see the **ADMINISTRATIVE INFORMATION** section.

Administrative Information

Insurance Premiums

How Premiums are Established and Changed - Premiums are the monthly charges the member must pay Anthem to establish and maintain coverage. Anthem determines and establishes the required premiums based on the member's age and the specific regional area in which the member resides. If the member changes residence, he or she may be subject to a change in premiums, without prior written notice from Anthem. Such change in premiums will be effective on the next billing date following Anthem's receipt of written notification of the change of residence. If the member does not notify Anthem of a change in residence and Anthem later learns of the change in residential address, Anthem may in its discretion bill the member for the difference in premium from the date the address changed. Anthem is not required to notify the member of a premium increase when a member enters into a new age bracket. Prior to any other premium change, Anthem reserves the right to change the premiums on thirty (30) days written notice to the Policyholder prior to the close of any billing term. The change will become effective on the date shown in the notice and payment of the new charges will indicate acceptance of the change in premium amount.

CoverColorado or Similar Assessments: In addition, you will be responsible for any charge necessary to recover any assessment billed for CoverColorado or any similar state or federal program. This amount is separate from and in addition to the premium charges under this policy. Failure to pay this charge may result in termination of your policy, subject to the terms herein.

How and When to Pay Premiums - The premiums printed on your individual rate sheet are payable in advance and due the first of the month. There are different billing options available:

Paper Bill:

- Quarterly (3 months)
- Bi-Monthly (2 months)
- Monthly (1 month)

Electronic Check / Electronic Funds Transfer: If the member receives billing statements by mail and submits a personal check for premium payments, the member automatically authorizes Anthem to convert that check into an electronic payment. Anthem will store a copy of the check and destroy the original paper check. The member's payment will be listed on the member's bank or credit union account statement as an Electronic Funds Transfer (EFT). Converting the member's paper check into an electronic payment does not authorize Anthem to deduct premiums from your account on a monthly basis unless the member has given Anthem prior authorization to do so.

Monthly Checking Account Automatic Premium Payment/Payment by Credit or Debit Card

- Monthly (1 month)

The member will be responsible for an additional \$25 charge for any check which is returned or dishonored by the bank as non-payable to Anthem for any reason.

Note: We may offer incentives to members who enroll to automatically pay premiums electronically instead of receiving a paper bill every month.

Important: If enrolled in the checking account automatic premium payment program, the member must give Anthem thirty (30) days advance written notice to:

- Change banks
- Change account numbers
- Change account names
- Stop deduction or
- Re-start eligible deductions

For the above listed changes, a new authorization form is required. Anthem will be happy to send the member the necessary form upon request by calling Anthem at (800) 618-3145.

Administrative Information

It is the subscriber's responsibility to pay premiums to Anthem. Under no circumstances will premium payments made on any member's behalf or any member be accepted from a physician, a hospital or any other provider of the subscriber's health care services or any federal or state agency. The receipt of a premium payment from such a provider or agency may result in cancellation of the subscriber's coverage.

The subscriber must notify Anthem of an address change at least thirty (30) days in advance of the premium due date on which it is to be effective, by submitting an Enrollment Application/Change Form. If Anthem does not receive the member's written request at least thirty (30) days in advance of the premium due date, Anthem will not be able to make the requested change in time to coincide with the member's premium due date. Failure to receive a premium notice due to an unreported or untimely reported, address change (or any other reason) does not relieve the member from the responsibility to pay required premiums by the premium due date.

Premium Not Received on Time - If premiums are not paid within 31 days after the premium due date, coverage under this certificate will automatically terminate. Cancellation will be effective retroactively to the last date of the period for which premium has been paid. Anthem will not pay for any services provided to members on or after the date of cancellation. All claims paid for services incurred after termination will be retroactively adjusted, unless prohibited by applicable law. If Anthem is obligated to pay for claims incurred after the termination date, the subscriber shall remain liable for a pro-rata premium through the last date such claims were incurred..

Anthem will mail written notice of any intention not to renew this certificate for the period for which the premium has been accepted not less than 30 days prior to the premium due date. Anthem will mail the notice to the subscriber's latest address in Anthem's membership records.

Unpaid premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Grace Period – Unless not less than thirty days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted. A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

Reinstatement - When failure to pay insurance premiums results in termination, the member may have the option to reinstate the policy. Reinstatement is conditional and solely at Anthem's discretion. To apply for reinstatement, the subscriber must submit a written request to:

Anthem Blue Cross and Blue Shield
 Attn: Reinstatement Requests
 PO Box 9051
 Oxnard, CA 93031-9051

For Anthem to consider a reinstatement request, the subscriber must include all past due premiums and the current month's premium with the request. Premium payments submitted after termination without a written request will not constitute a request for reinstatement.

Anthem must receive a reinstatement request no later than the last day of the 31 day grace period, or the reinstatement request will automatically be denied. Any premium accepted in connection with the reinstatement shall be applied to a period for which premium has not been previously paid but not to any period more than 60 days prior to the date of reinstatement. You will be required to submit a new Enrollment Application/Change Form and any premiums and/or fees that are owed in addition to a \$50 reinstatement fee, and you will be subject to medical underwriting.

Anthem will notify the subscriber in writing of disapproval of the reinstatement request no later than 7 days after receiving the request for reinstatement. Deposit of premium payment does not constitute acceptance of request for reinstatement. Anthem will issue any applicable refunds if the request was denied. If the subscriber is reinstated, the policy will cover only accidental injury sustained after the date of reinstatement and sickness that begins more than 10 days after the date of reinstatement.

Refund Policy - The subscriber shall have the right to read the certificate and any amendments. If the subscriber is not satisfied for any reason, the subscriber may notify Anthem in writing within 30 days of the effective date to terminate the insurance coverage. Anthem will refund to the subscriber all premiums paid for that 30-day period unless benefits have been paid, in which case Anthem will use the premium payments to offset benefit payments. Anthem also reserves the right to recover any benefit payments Anthem has made for claims during that 30-day period.

Insurance With Other Insurers. Other Benefits:

If there is other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the 'like amount' of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

Insurance With Other Insurers. Expense Incurred Benefits:

If there is other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined.

How to File Claims

When a PPO or participating provider bills Anthem for covered services, Anthem will pay the appropriate charges for the benefit directly to the provider. The member is responsible for providing the PPO or participating provider with all information necessary for the provider to submit a claim. The member pays the applicable coinsurance and/or deductible to the provider when the covered service is received.

For non-participating providers and out-of-network pharmacies the member must complete the claim form and attach the itemized bill from the provider. Balance due statements, cash register receipts and cancelled checks are not accepted. All information on the claim form and itemized bill must be readable. When traveling outside the country, the member should obtain itemized bills translated to English. Charges for covered services should be stated in terms of United States currency. To determine the United State currency amount, use the exchange rate as it was on the date the member received care. If information is missing on the claim form or is not readable, the form will be returned to the member. The information contained on the itemized bills will be used to determine benefits, so it must support information reported on the submitted claim form. The claim form contains detailed instructions on how to complete the form and what information is necessary.

We pay benefits of this Certificate to Participating and Non-Participating Providers, when you have authorized assignment of benefits. Anthem may require a copy of the assignment of benefits for our records. These payments fulfill our obligation to you for those services.

A separate claim form is required for each non-participating provider for which the member is requesting reimbursement.

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

Administrative Information

When a member obtains health care services through BlueCard® outside the geographic area Anthem serves, the amount the member pays for covered services is calculated on the **lower** of:

- The billed charges for the covered services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan (“Host Blue”) passes on to Anthem.

Often, this “negotiated price” will consist of a simple discount that reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements, withhold, any other contingent payment arrangements, and non-claims transactions with the member’s health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an **average** expected savings with the member’s health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount the member pays is considered a final price.

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

Claim Forms: If a non-participating provider does not bill Anthem directly, the member must file the claim. To obtain claim forms, contact Anthem’s customer service department. If Anthem does not furnish a claim form to the member within 15 days of the member’s request, the member may submit written proof of the claim and will be considered to have complied with the requirements of this certificate. The member must complete the claim form and attach the itemized bill from the provider. Balance due statements, cash register receipts and cancelled checks are not accepted. All information on the claim form and itemized bill must be readable. When traveling outside the country, the member should obtain itemized bills translated to English. Charges for covered services should be stated in terms of United States currency. To determine the United State currency amount, use the exchange rate as it was on the date the member received care. If information is missing on the claim form or is not readable, the form will be returned to the member. The information contained on the itemized bills will be used to determine benefits, so it must support information reported on the submitted claim form. The claim form contains detailed instructions on how to complete the form and what information is necessary.

We pay the benefits of this Certificate to Participating and Non-Participating Providers when an assignment of benefits has been authorized. Anthem may require a copy of the assignment of benefits for our records. If Anthem pays you directly, you are responsible for paying the provider of services for all charges. These payments fulfill our obligation to you for those services.

Where and When to Send Claims - A claim must be filed **within 365 days** after the date of service. Any claims filed after this limit may be refused. Failure to file a claim within such time will not invalidate or reduce any claim if it is shown that it was not reasonably possible to give such notice and that notice was given as soon as reasonably possible.

Time of payment of claims:

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

Administrative Information

Notice of claim: Written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at:

Anthem Blue Cross and Blue Shield
Attn. Claims Department
P.O. Box 5747
Denver, CO 80217-5747

Claims sent to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. 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 Blue Cross and Blue Shield
Attn. Claims Department
P.O. Box 5747
Denver, CO 80217-5747

Payment of claims: 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 PPO or 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

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.

Change of beneficiary: 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 PPO or participating provider, claims payments will be made to the provider.

Change of occupation: If the insured is injured or contracts sickness after having changed the insured's occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes the insured's occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

Changes to the Certificate - No agent of Anthem may change this certificate by giving incomplete or incorrect information, or by contradicting the terms of this certificate. Any such situation will not prevent Anthem from administering this certificate in strict accordance with its terms. Oral or written statements do not supercede the terms of this certificate.

Conformity with state statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Contracting Entity - The subscriber hereby expressly acknowledges that the subscriber understands that the certificate 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 certificate. This paragraph does not create any additional obligations whatsoever on Anthem's part other than those obligations created under other provisions of the certificate.

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

Entire Contract – Changes: This policy including the endorsements and attached papers if any constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provision.

Administrative Information

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 insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for 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 coverage. Members can help decrease these costs by doing the following:

- Be wary of offers to waive deductible and/or coinsurance. This practice is usually illegal.
- Be wary of mobile health testing labs. Ask what the insurance company will be charged for the tests.
- Always review the Explanation of Benefits received from Anthem. If there are any discrepancies, call Anthem's customer service department.
- Be very cautious about giving the member's health insurance coverage information over the phone.

If fraud is suspected, members should contact Anthem's customer service department.

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

Independent Contractors - Anthem has an independent contractor relationship with Anthem's PPO or participating providers; physicians and other providers are not Anthem's agents or employees, and Anthem's employees are not employees or agents of any of Anthem's PPO or 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 PPO or participating providers by reason of negligence or otherwise.

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 customer service duties on Anthem's behalf.

Member's Obligation to Supply Information and Cooperate – The member must provide Anthem with any information Anthem considers necessary to determine whether, or to what extent, services are covered under this certificate, or to carry out the other provisions of this certificate.

The member agrees to cooperate at all times (including while they are hospitalized) by allowing Anthem access to their medical records to investigate claims and verify information provided in the member's Enrollment Application and Change Form and/or Health Statement.

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

Misstatement of age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have been if purchased at the correct age.

Network Access Plan - Anthem strives to provide an extensive provider network in Colorado that adequately addresses members' 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 customer service 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, 80273, in the customer service department.

Administrative Information

Notice of claim: Written notice of injury on which claim is based must be given to Anthem Life within 20 days after the date of the accident causing such injury. Such notice given by or on behalf of the subscriber to Anthem Life at its home office or to any authorized agent of Anthem Life, with particulars sufficient to identify the subscriber, shall be deemed to be notice to Anthem Life. Failure to give notice within the time provided herein shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as reasonably possible.

Notice of Privacy Practices – Anthem is committed to protecting the confidential nature of members' medical information to the fullest extent of the law. In addition to various laws governing member privacy, Anthem has its own privacy policies and procedures in place designed to protect member information. Anthem is required by law to provide individuals with notice of Anthem's legal duties and privacy practices. To obtain a copy of this notice, visit Anthem's website or contact Anthem's customer service department.

No Withholding of Coverage 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 certificate.

Anthem does not design, calculate, award or permit financial or other incentives based on the frequency of: (1) denials of authorization for coverage; (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.

Other insurance in this insurer: Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, the insured's beneficiary, or the estate of the insured, as the case may be, and the insurer will return all premiums paid for all other such policies.

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

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

Proofs of loss: Written proof of loss must be furnished to Anthem at its home within ninety (90) days after the date of the loss for which claim is made. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within such time. In no event, except in the absence of legal capacity of the claimant, shall proof be furnished later than one year from the date proof of loss is otherwise required.

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.

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 the subscriber at the latest address in Anthem's membership records.

Time Limit on Certain Defenses - After two years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the subscriber in the application for such policy will be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

The foregoing policy provision shall not be so construed to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of information in this provision in the event of misstatement with respect to age or occupation or other insurance.

Administrative Information

After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the Enrollment Application/Change Form.

No claim for loss incurred or disability, as defined in the policy, commencing after one year from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or a specific description effective on the date of loss existed prior to the effective date of coverage of this policy.

An individual health benefit coverage shall not define a pre-existing condition more restrictively than an injury, sickness or pregnancy for which a person incurred charges, received medical treatment, consulted a health care professional or took prescription drugs within the 12 months immediately preceding the effective date of coverage.

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 certificate, except for corporate officers who may opt out of Workers' Compensation coverage, pursuant to state or federal law. This exclusion from coverage 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 or motorcycle 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 Revised Statutes §§ 10-4-601 et seq. Any state or federal law requiring similar benefits through legislation or regulation is also considered a complying policy.

How Anthem Coordinates Benefits with Complying Policies – The member benefits under this Certificate may be coordinated with the coverages afforded by a complying policy. After any primary coverages offered by the complying policy are exhausted, including without limitation any no-fault, personal injury protection, or medical payment coverages, 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.

The member, the member's representatives, agents and heirs 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 under this Certificate. Alternatively, Anthem may but is not be 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 and Right of Reimbursement*.

What Happens If a Member Does Not Have Another Policy – Anthem will pay benefits for injuries the member receives while 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 the member sustains if as a non-owner-operator, passenger or pedestrian involved in a motor vehicle accident if those injuries are not covered by a complying policy. In that event, Anthem may exercise the rights found in the **ADMINISTRATIVE INFORMATION** section, under the heading *Third Party Liability: Subrogation and Right of Reimbursement*.

Third Party Liability: Subrogation and Right of Reimbursement

These provisions apply when Anthem pays benefits as a result of injuries or illness and another party or parties agree to pay money because of these injuries or the member has a right to a Recovery or have received a Recovery because of these injuries or illnesses.

Subrogation

Anthem has the right to recover payments it makes on the member's behalf. The following apply:

- Anthem has the first priority lien for the full amount of benefits it has paid from any Recovery, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, the member's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage, a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness. The Anthem first priority lien exists regardless of whether the member is fully compensated, and regardless of whether the payments the member receives makes the member whole for losses and injuries.
- The member and the member's legal representative must do whatever is necessary to enable Anthem to exercise its rights and do nothing to prejudice them.
- Anthem has the right to take whatever legal action it sees fit against any party or entity to recover the benefits paid under this Certificate.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Anthem subrogation claim and any claim still held by the member, the Anthem subrogation claim shall be first satisfied before any part of a Recovery is applied to the member's claim, the member's beneficiary's claims (if applicable), the member's attorney fees, other expenses or costs.
- Anthem is not responsible for any attorney fees, other expenses or costs incurred without its prior written consent. Anthem and the member further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney hired regardless of whether funds recovered are used to repay benefits paid by Anthem.

Right of Reimbursement

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

- The member must reimburse Anthem to the extent of benefits Anthem paid on the member's behalf from any Recovery, including, but not limited to, the party or parties who caused the injuries or illness, the insurer or other indemnifier of the party or parties who caused the injuries or illness, a guarantor of the party or parties who caused the injuries or illness, the member's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage, a worker's compensation insurer), or any other person, entity, policy or plan that may be liable or legally responsible in relation to the injuries or illness.

Administrative Information

- Notwithstanding any allocation made in a settlement agreement or court order, Anthem shall have a right of Recovery, in first priority, against any Recovery.
- The member, the member's legal representative, or beneficiary must hold in trust for Anthem 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 Anthem immediately upon receipt of the Recovery. The member, the member's legal representative, or beneficiary must reimburse Anthem, 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 the member, the member's legal representative, or beneficiary may hire regardless of whether funds recovered are used to repay benefits paid by Anthem.

If the member, the member's legal representative, beneficiary fails to repay Anthem, Anthem shall be entitled to deduct any of the unsatisfied portion of the amount of benefits it has paid or the amount of any Recovery whichever is less, from any future benefit under the Certificate if:

- The amount Anthem paid is not repaid or otherwise recovered by Anthem; or
- The member fails to cooperate.
- In the event that the member, the member's legal representative, or beneficiary fails to disclose to Anthem the amount of any settlement, Anthem shall be entitled to deduct the amount of its lien from any future benefit under the Certificate.
- Anthem shall also be entitled to recover any of the unsatisfied portion of the amount it has paid or the amount of any settlement, whichever is less, directly from the providers to whom Anthem has made payments, to the extent not prohibited by law. In such a circumstance, it may then be the obligation of the member, the member's legal representative, or beneficiary to pay the provider the full outstanding amount, and Anthem would not have any obligation to pay the provider.
- Anthem 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 or make the member or the recovering party whole.

The Member's Duties

- The member, the member's legal representative, or beneficiary must notify Anthem promptly of how, when and where an accident or incident resulting in personal injury or illness to the member occurred and all information regarding the parties involved.
- The member, the member's legal representative, or beneficiary must cooperate with Anthem in the investigation, settlement and protection of its rights.
- The member, the member's legal representative, or beneficiary must not do anything to prejudice the rights of Anthem.
- The member, the member's legal representative, or beneficiary must send Anthem copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness.
- The member, the member's legal representative, or beneficiary must promptly notify Anthem if you retain an attorney or if a lawsuit is filed
- If the member, the member's legal representative, or beneficiary resides in a state where automobile personal injury protection or medical payment coverage is mandatory, that coverage is primary and the certificate takes secondary status. The certificate will reduce benefits for an amount equal to, but not less than, that state's mandatory minimum personal injury protection or medical payment requirement.

NOTE: Failure to comply with obligations in this section may result in termination of coverage under this certificate.

Complaints, Grievances and Appeals

Complaints, Appeals and Grievances

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 customer service 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 customer service associate, the member may file an appeal as explained under the heading *Appeals* in this section:

Anthem Blue Cross and Blue Shield
 Customer Service Department
 P.O. Box 5747
 Denver, CO 80217-5747

Appeals

While Anthem encourages members to file appeals within 60 days of an adverse benefit determination, the member's written appeal must be received by Anthem within 180 days of the adverse benefit determination. Appeals may be for pre-service denials or post-service denials. Anthem will assign a customer advocate to assist the member in the appeal process. Members may send written appeals to the following address:

Anthem Blue Cross and Blue Shield
 Member Appeals Department
 700 Broadway CAT 0430
 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) 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 – At this appeal level, Anthem appoints an internal person(s) not involved in the initial determination to review the denial of the claim or requested service or supply. A person who 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, where required to do so by applicable law or regulation. For pre-service and post-service utilization review issues, the member will receive a response to the member's Level 1 Appeal within 20 business days (or no later than 30 calendar days) of receipt of the appeal request. Non-utilization pre-service review appeals will typically be resolved within 30 calendar days. Non-utilization post-service appeals will be resolved in 60 calendar days.

Complaints, Grievances and Appeals

Level 2 Appeal – This is a voluntary level of 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 teleconferenced in to present testimony, introduce documentation the member believes supports the member's 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 comprised of Anthem associates who have appropriate professional expertise. A majority of the panel shall be 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:

- They have not previously been involved in the member's care.
- They are not members of the health plan's board of directors.
- They have not previously been involved in the review process for the member.
- They 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 business days of Anthem's receipt of the Level 2 Appeal request. The appeal decision timeframes may be extended if the member requests or voluntarily agrees to the extension.

Expedited Appeals – A member or member's representative has the right to request an expedited appeal of a utilization review decision when the timeframes for a standard review would seriously jeopardize the member's life or health; jeopardize the member's ability to regain maximum function; or, for persons with a disability, create an imminent and substantial limitation on the member's existing ability to live independently. Typically the decision will be made as soon as possible, but no later than 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.

Independent External Review Appeals – Independent External Review Appeals are conducted by independent external review entities, which are selected by the Colorado Division of Insurance. Unless a applicable statute specifically states otherwise, Independent External Review Appeals are available only when claims or requested services or supplies were denied based on utilization review, and which have gone through Anthem's Level 2 Appeal process. To request an Independent External Review Appeal, the member or member's representative must complete and submit a written request on the Request for Independent External Review of Carrier's Final Adverse Determination Form. This form is available through Anthem's customer service department. The request must be made to Anthem within 60 calendar days after the date of receipt of notice of Anthem's Level 2 Appeal denial. The Division of Insurance will assign an independent external review entity to conduct the review. The independent reviewer's decision will be made within 30 business days after Anthem receives a request for such a review. This timeframe may be extended up to 10 business days for the consideration of additional material if requested by the independent external review entity.

Expedited Independent External Review Appeals – Expedited Independent External Review Appeals reviews may be requested by a member or the member's representative if the member has a medical condition where the timeframe for a standard independent external review appeal would seriously jeopardize the member's life or health; jeopardize member's ability to regain maximum function; or, for persons with a disability, create an imminent and substantial limitation on the member's existing ability to live independently. The member's request must include a physician's certification that the member's medical condition meets the criteria for an Expedited Independent External Review Appeal. The request must be made on the form referenced in the previous paragraph. Determinations will be made by the independent external review entity within seven business days after Anthem receives a request for an Expedited Independent External Review Appeal. This timeframe may be extended for an additional five business days for the consideration of additional information if requested by the independent external review entity. An Expedited Independent External Review Appeal may not be provided for retrospective denials

Complaints, Grievances and Appeals

Grievances

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

Anthem Blue Cross and Blue Shield
 Quality Management Department
 700 Broadway MC0532
 Denver, CO 80273

Receipt of the member's grievance will be acknowledged by Anthem's Member Grievances Department and the grievance will be investigated by Anthem's Member Grievances Department. Anthem treats each grievance investigation in a strictly confidential manner.

Division of Insurance Inquiries

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

Binding Arbitration

Any and all disputes between Anthem and the member must be resolved by Binding Arbitration, if the amount in dispute exceed the jurisdictional limit of the Small Claims Court. Under this Binding Arbitration requirement, the member and Anthem are giving up the Constitutional right to have the dispute decided in a court of law by a jury.

Before commencing arbitration, the party seeking arbitration must have exhausted all levels of appeal and review set forth in this Certificate. Any such arbitration will be governed by the procedures and rules established by the American Arbitration Association. The law of the state in which the policy was issued and delivered to the Policyholder shall govern the dispute. The decision in arbitration is binding upon both the member and Anthem. The award given in arbitration may be enforced or reviewed in any court that has proper jurisdiction. In the event any person subject to this arbitration clause initiates legal action of any kind, the other party may apply for a Court of Competent Jurisdiction to enjoin, stay or dismiss any such action and direct the parties to arbitrate in accordance with this provision. The question of what disputes are subject to this arbitration clause shall be determined by the arbitrator.

Legal Actions

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 certificate.

Legal Actions: No action in law or in equity shall be brought to recover on this certificate prior to expiration of 60 calendar days after a claim has been filed in accordance with the requirements of this certificate. No such action shall be brought at all unless brought within three years from the date proof of loss is otherwise required.

Glossary

This section defines words and terms used throughout the certificate to help members understand the content. Members should refer to this section to find out exactly how, for the purposes of this certificate, 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.

Alcoholism/substance treatment center — a detoxification and/or rehabilitation facility licensed by the state to treat alcoholism/drug abuse.

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

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

Ambulatory — not confined to bed; able or strong enough to walk

Ambulatory Surgery Center — a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association of Ambulatory Health Care.

Ancillary services — auxiliary or secondary 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 an individual renews their coverage.

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."

Anthem Specialty Drug List — a list of Specialty Pharmacy Drugs as determined by Anthem.

 Glossary

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

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

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

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

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

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

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.

Certificate — this document, which explains the benefits, limitations, exclusions, terms and conditions of the health coverage.

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.

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

Coinsurance — a provision under which the subscriber and Anthem share costs incurred after the deductible is met, according to a specific formula. The amount of coinsurance the member pays to a provider is calculated after the determination of the maximum benefit allowance, but after Anthem subtracts any discount(s) Anthem may have negotiated with the provider.

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

Complaint — an expression of dissatisfaction with Anthem's services or the practices of an in-network provider, whether medical or non-medical in nature.

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

Consultation/second opinion — a service provided by another physician who gives an opinion about the treatment of the member's condition. The consulting physician often has specialized skills that are helpful in diagnosing or treating the illness or injury.

Convalescent care — the period of time needed for returning to health after illness.

Glossary

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 or domestic partner's policy. Eligible medical expenses are covered first by a person's own policy. Any balance is submitted to the spouse or domestic partner'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 — beautification procedures, services or surgery of a physical characteristic to improve an individual's appearance.

Cost sharing — the general term for out-of-pocket expenses, e.g., deductibles and coinsurance, paid by a member.

Covered services — supplies or treatments which are:

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

Creditable coverage — a qualified prior health coverage that a member and/or dependent had within 90 days prior to the effective date of Anthem's coverage. Prior creditable health coverage includes Medicare or Medicaid coverage, a group health insurance coverage, an individual health benefit coverage, state high risk pool coverage, any federal or state health benefit coverage or any other health benefit coverage that provides basic medical and hospital care, including, but 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 services.

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

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

Domestic Partner is a person, other than a spouse, with whom one cohabits. A domestic partner is only eligible for coverage if: he or she has been the subscriber's sole domestic partner for 12 months or more; is mentally competent; is at least 18 years old; is not related to the subscriber in any way (including by blood or adoption) that would prohibit marriage under state law; is not married to or separated from anyone else; and is financially interdependent with the subscriber.

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

Effective date — the date coverage under this certificate 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.

Glossary

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 (except as noted in the Clinical Trials section under Member Benefits in this Certificate as required by Colorado law), or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as experimental/investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

(b) Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by 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

Glossary

- 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.

Health Benefit Plan Description Form — the state regulated document, found in the front of the certificate, which identifies the type of coverage, copayment, deductible and coinsurance information.

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

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, physical, speech, occupational therapy, infusion therapy and other health-related services provided for patients confined to their homes except for brief absences 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.

 Glossary

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 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.

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

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 patients, extensive wound care or post operative surgery wound patients, and low level closed head injury patients. LTAC facilities do not provide care for low intensity patient needs.

Mail Service Pharmacy — an establishment licensed to dispense Prescription Drugs and other medications (other than Specialty Pharmacy Drugs) through a mail order service upon an authorized health care professional's order.

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 coverage performance.

Maximum benefit allowance — the maximum dollar amount determined and approved by Anthem which Anthem allows for covered services and procedures. Anthem's determination of a maximum benefit allowance is the maximum amount Anthem approves for any particular service. Cost sharing amounts are based on this allowance and on the allowance and are the amounts the member pays to a provider.

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.

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

Glossary

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 mean lowest cost).
- Not experimental/investigational.
- Not primarily for the convenience of the member, the member’s family or the provider.
- Not otherwise subject to any exclusion under this certificate.

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

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

Member — the subscriber or any dependent who is enrolled for coverage under this certificate. Also referred to in this Certificate as “you” or “your.” In some instances you or your could also mean a surrogate decision-maker. Anthem will accept the guidance of your surrogate decision-maker in those situations as required by state law.

Mental health condition — non-biologically based mental conditions with a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (e.g., depression secondary to diabetes or primary depression).

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

Nephritis — infection or inflammation of the kidney.

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

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

- A facility provider, such as a hospital, that has not entered into an agreement with Anthem
- A professional provider, such as a physician, who has not entered in to an agreement with Anthem
- Providers who have not contracted or affiliated with Anthem’s designated subcontractor(s) for the services they perform under this certificate

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.

 Glossary

Office visit — when a member visits a physician's office or urgent care center and has one or more of **only** the following services provided:

- History (gathering of information on an illness or injury)
- Examination
- Medical decision making (the physician's actual diagnosis and treatment plan)

For purposes of this definition, office visits do not include services, other than those described above, that may be received while at the office of a physician or urgent care center (including, but not limited to, any surgery, infusion therapy, diagnostic x-ray, laboratory, pathology and radiology).

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 providers or facilities that do not enter into a network agreement with Anthem, usually at a higher out-of-pocket expense to members than services rendered by an in-network provider.

Out-of-pocket annual maximum — the cost sharing total a member may be liable for under this certificate 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 calendar year, after the out-of-pocket annual maximum is reached, for most services payment will be made at 100 percent of the allowable charge for the remainder of the calendar year. Calendar year maximums, Lifetime Maximums or maximum dollar limitations under this Certificate 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.

Palliative — Relieving or soothing the symptoms of a disease or disorder without effecting a cure.

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

Participating provider — a facility provider (such as a hospital) or a professional provider (such as a physician) that has entered into an agreement with Anthem or another Blue Cross and Blue Shield Plan to bill Anthem directly for covered services, and to accept Anthem's maximum benefit allowance as the maximum amount of payment for covered services the participating provider must bill the member for or use to calculate cost sharing amounts for covered services.

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

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

PPO provider — a participating facility provider or a participating professional provider that has entered into an additional agreement with Anthem, to limit charges for services performed under this certificate.

Preauthorization — a process in which requests for services are reviewed prior to service for approval of benefits, length of stay and appropriate location.

Premium — monthly charges that the member must pay to establish and maintain coverage.

Glossary

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

Generic prescription drug — drugs determined by the FDA to be bio-equivalent to brand name drugs and that are not manufactured or marketed under a registered trade name or trademark. A generic drug's active ingredients duplicate those of a brand name drug. Generic drugs must meet the same FDA specifications as brand name drugs for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, and cream) as the counterpart brand name drug. Generic drugs offer the same therapeutic outcomes as their brand name counterparts with significant cost savings.

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

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

Pharmacy — an establishment licensed to dispense prescription drugs and other medications through a licensed pharmacist upon a 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 with Anthem to provide covered drugs to members under the terms and conditions of this certificate. An out-of-network pharmacy is **not** contracted with Anthem and services are not covered.

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

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

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 certificate. 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, chiropractors, massage therapists and registered dietitians. Services of such a provider must be among those covered by this certificate and are subject to review by a medical authority appointed by Anthem.

Glossary

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 certificate 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 mastoplasty.

Reconstructive surgery — effecting this Certificate, 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 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 Subrogation and Right of Recovery provisions of this Certificate.

Referral — authorization given to a member to visit another provider.

Resident — an individual who maintains legal domicile within the state of Colorado and is presumed, for purposes of this agreement, to be a primary resident of the state, as evidenced by any three of the following:

- Payment of Colorado income tax
- Employment in Colorado, other than that normally provided on a temporary basis to students
- Ownership of residential real estate property in Colorado
- State identification card or drivers license
- Acceptance of future employment in the state of Colorado
- Vehicle registered in Colorado
- Voter registration in Colorado
- Phone bill or utility bill from Colorado

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

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.

 Glossary

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 non-surgical 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 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.

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

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

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

Sub-acute rehabilitation — care that includes a minimum of one hour of therapy when 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.

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.

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).

 Glossary

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 certificate 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.

Year — a twelve (12) month period starting each January 1 at 12:01 a.m. Mountain Standard Time.