County Health Pool

PPO Plan B500
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF MEDICAL BENEFITS

CTSI
Serving Colorado's Counties

Effective January 1, 2022

County Health Pool
PPO Plan B500 Benefit Summary
Effective January 1, 2022

	PPO PLAN B500	
	IN-NETWORK	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE		
Individual	$500	$2,000
Family	$1,000	$4,000 aggregate
OUT-OF-POCKET ANNUAL MAXIMUM		
Individual	$3,750, including deductible. Medical and Rx Co-payments, deductible and coinsurance do apply to the out-of pocket maximum	$9,000, including deductible. Medical and Rx Co-payments and coinsurance do apply to the out-of-pocket maximum.
Family	$9,500, including deductible. Medical and Rx Co-payments, deductible and coinsurance do apply to the out-of pocket maximum Once the OOP maximum has been met, medical and Rx copayments and coinsurance do not apply.	$25,000, including deductible. Medical and Rx Co-payments and coinsurance do apply to the out-of-pocket maximum. Once the OOP maximum has been met, medical and Rx copayments and co-insurance do not apply.
LIFETIME MAXIMUM	None	None
Pre-Cert Penalty	None	May be balance billed, see Plan Document for details
COVERED PROVIDERS	Anthem Blue Cross and Blue Shield Blue Preferred PPO Provider Network. Consult www.anthem.com or call Member Service at 1-866-698-0087	All eligible providers licensed or certified to provide covered benefits
MEDICAL OFFICE VISITS	$35 per office visit copayment, plus 80/20% coinsurance after deductible for all other eligible services (e.g., laboratory and x-ray services including testing and treatment of COVID-19, as required under any applicable Federal law)) or $200 co-payment plus 80/20% after deductible for high tech lab and x-ray, (i.e. MRI, MRA, PET, CT scans, etc.)	60/40% after deductible or $200 co-payment plus 60/40% coinsurance after deductible for high tech lab and x-ray,(i.e. MRI,MRA, PET, CT Scans, etc.)
PREVENTIVE CARE		
Children's services (age/visit limitations apply)	100% covered, not subject to co-payment, deductible or co-insurance.	60/40% not subject to deductible, includes immunizations (up to age 13)
Adults' services (age/visit limitations apply)	100% covered, not subject to co-payment, deductible, or co-insurance Annual flu shots are covered at 100% not subject to, deductible or coinsurance. Physicals for Department of Transportation	Not covered except for mammogram screening, PSA and colorectal cancer screenings.60/40 not subject to deductible. See SPD for benefit limit.

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	Commercial Driver License are covered at 100% not subject to copayment, deductible or coinsurance once every 24 months(An additional DOT-CDL physical required to maintain the CDL for the Members job within 12 months based upon a medical condition will be covered in addition to the 24 month CDL.) Annual Health Fair Reimbursement ($40 max) Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations, contraceptives and office visits; and are not subject to coinsurance or deductible.	Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations, contraceptives and office visits.
MATERNITY **Prenatal care**	$35 per office visit copayment + 80/20% after deductible for all other eligible services (e.g., laboratory and x-ray services)	60/40% after deductible
Delivery & inpatient care	80/20% after deductible	60/40% after deductible
PRESCRIPTION DRUGS **(**Level of coverage and restrictions on prescriptions)	Prescription drugs have a separate $75 deductible, combined for retail and mail order	
Inpatient care	Included with inpatient hospital benefit	Included with inpatient hospital benefit
Outpatient care	Per prescription at a participating pharmacy up to a 30-day supply: Tier 1 generic formulary $10 or 15% copayment, whichever is the higher amount. Tier 2 brand formulary $25 or 25% copayment. Tier 3 non-formulary $35 or 45% copayment.	Not covered
Prescription Mail Service	Per prescription through the mail-order service up to a 90-day supply. .(Specialty Drugs included in	Not covered

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	90-day mail order supply) Tier 1 generic formulary $25 copayment. Tier 2 brand formulary $60 copayment. Tier 3 non-formulary $115 copayment . Includes coverage for smoking Cessation Benefit If you choose a brand-name drug or your provider prescribes a brand-name drug, and a generic formulary drug is available, you pay the brand formulary tier 2 copayment plus the retail cost difference between the brand-name drug and generic substitute. If you choose a non-formulary drug or your provider prescribes a non-formulary drug, and a formulary drug is available, you pay the non-formulary tier 3 copayment plus the retail cost difference between the non-formulary drug and formulary substitute. For drugs on our approved list, call Member service toll free at 1-866-698-0087. Covered only when received from a participating pharmacy.	
INPATIENT HOSPITAL	80/20% after deductible	60/40% after deductible
OUTPATIENT/AMBULATORY SURGERY	80/20% after deductible	60/40% after deductible
LABORATORY AND X-RAY **Inpatient care**	80/20% coinsurance after deductible, or $200 co-payment plus 80/20% coinsurance after deductible for high tech lab and x-ray, (i.e. MRI, MRA, PET, CT scans, etc.)	60/40% after deductible, or $200 co-payment plus 60/40% coinsurance after deductible for high tech lab and x-ray, (i.e. MRI, MRA, PET, CT scans, etc.)
Outpatient care	80/20% coinsurance after deductible, or $200 co-payment plus 80/20% coinsurance after deductible for high tech lab and x-ray, (i.e. MRI, MRA, PET, CT scans, etc.)	60/40% after deductible, or $200 co-payment plus 60/40% coinsurance after deductible for high tech lab and x-ray, (i.e. MRI, MRA, PET, CT scans, etc.)
EMERGENCY CARE (Emergency Room)	80/20% after deductible	Paid as in network benefit.
AMBULANCE **Ground**	80/20% after deductible	Paid as in network benefit.

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Air	80/20% after deductible	Paid as in network benefit.
URGENT, NON-ROUTINE, AFTER HOURS - OUTPATIENT CARE	$35 per office visit copayment, 80/20% after deductible for all other eligible services (e.g., laboratory and x-ray services)	60/40% after deductible
MENTAL HEALTH CARE		
Inpatient care	80/20% after deductible	60/40% after deductible
Outpatient facility	$35 co-payment per office visit, 80/20% after deductible for all other eligible services, including facility care	60/40% after deductible
ALCOHOL & SUBSTANCE ABUSE		
Inpatient Care	80/20% after deductible	60/40% after deductible
Outpatient facility	$35 co-payment per office visit, 80/20% after deductible for all other eligible services, including facility care	60/40% after deductible
PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY		
Inpatient	80/20% after deductible	60/40% after deductible
Outpatient	$35 per office visit copayment,80/20% after deductible for all other eligible services (e.g., laboratory and x-ray services), limited to 30 visits each (PT, OT, ST) per calendar year in- and out-of-network combined	60/40% after deductible, limited to 30 visits each (PT, OT, ST) per calendar year in- and out-of-network combined
DURABLE MEDICAL EQUIPMENT/OXYGEN		
Inpatient care	80/20% after deductible	60/40% after deductible
Outpatient care	80/20% after deductible	Not covered
ORGAN TRANSPLANTS	80/20% after deductible	Not covered
HOME HEALTH CARE	$35 per visit copayment, 80/20% after deductible for all other eligible services (e.g., laboratory and	Not covered

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	x-ray services), limited to 60 visits per calendar year	
HOSPICE CARE **Inpatient Care** **Outpatient care**	 80/20% after deductible 80/20% after deductible	 60/40% after deductible 60/40% after deductible
SKILLED NURSING FACILITY CARE	80/20% after deductible, limited to 30 days per calendar year in- and out-of-network combined	60/40% after deductible, limited to 30 days per calendar year in- and out-of-network combined
CHIROPRACTIC CARE **ACUPUNCTURE CARE**	$35 copayment per office visit, 80/20% after deductible for all other eligible expenses, limited to 30 visits per calendar year in- and out-of-network combined	60/40% after deductible, limited to 30 visits per calendar year in- and out-of-network combined
ACUPUNCTURE CARE	$35 copayment per office visit, 80/20% after deductible for all other eligible expenses, limited to 30 visits per calendar year in- and out-of-network combined	60/40% after deductible, limited to 30 visits per calendar year in- and out-of-network combined
SECOND SURGICAL OPINION	When a member desires another professional opinion, they may obtain a second surgical opinion	When a member desires another professional opinion, they may obtain a second surgical opinion
TREATMENT OF AUTISM SPECTRUM DISORDERS	Benefit level and coverage meets the requirements of federal and state laws. More information on this benefit can be found in the Plan Document.	Benefit level and coverage meets the requirements of federal and state laws. More information on this benefit can be found in the Plan Document
Your plan may exclude coverage for certain treatments, diagnoses, or services not noted. The benefits shown in this summary may only be available if required plan procedures are followed (e.g. plans may require prior authorization or use of specified providers or facilities).		

This form is not a contract, and is only a summary. The contents of this form are subject to the provisions of the Plan Document and Summary Plan Description which contains all terms, covenants, and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted. The benefits shown in this summary may only be available if required plan procedures are followed (e.g. plans may require prior authorization or use of specified providers or facilities). Consult the actual Plan Document and Summary Plan Description to determine the exact terms and conditions of coverage. The County Health Pool Plan Document may be accessed at www.ctsi.org. You may also contact Anthem Member Service at 1-866-698-0087.

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Statement of Enrollee Rights

As an Enrollee in the Plan, an individual is entitled to certain rights including the right to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents.
- Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- To the extent required or permitted by law, give or withhold consent regarding use and disclosure of protected health information, request privacy of such information and request amendment or correction of such information.
- Expect proper and equitable treatment from the persons who are responsible for the operation of the Plan.

About Your Health Benefits

County Health Pool (CHP) has contracted with Anthem Blue Cross and Blue Shield (Anthem) to administer this Preferred Provider Organization (PPO) health benefit plan for medical services, which means Enrollees have in-network (Participating) and out-of-network (non-Participating) benefits. This PPO structure brings patients and selected health care Providers together in an effort to reduce the effect of rising health care costs. The Participating Providers have been carefully selected and the qualifications of each Participating Provider have been reviewed in an effort that the Enrollee will be provided quality care.

The Enrollee must make the final choice of health care Providers. If care is received from a Provider that is not included in the PPO network, the Plan will pay a smaller percentage of the cost of the care, as further outlined herein. Benefits paid to a Participating Provider will be paid directly to the provider of service. When using a Participating Provider, the Enrollee is responsible for the payment of the deductible, coinsurance or copayment.

In-network benefits are services provided to Enrollees by Providers who are participants in the Plan network as described under the heading "Participating Providers" in this section.

This PPO plan offers great flexibility because Enrollees may choose how to use their benefits and to control their out-of-pocket expenses. When Enrollees use their PPO in-network benefits, they receive the highest level of benefits at the lowest cost. The *Benefit Summary* lists payment levels for both in- and out-of network care.

We publish a directory of Participating Providers. Enrollees may get a directory from Anthem by calling the Member Service number that is listed on the identification card, or you may write Anthem and ask that a directory be sent. Enrollees may also search for a Provider on-line at www.anthem.com.

Providers

Participating Providers

Participating Providers have entered into a network agreement with Us for this specific health benefit program. Covered Services provided by a Participating Provider are considered In-Network. When you visit a Participating Provider you have lower out-of-pocket expenses. Your In-Network Cost Sharing responsibilities to Participating Providers may be found on the *Benefit Summary* under the "In Network" heading. You are responsible for determining if your Provider is a Participating Provider. You may visit Our website or call Our Member Service department for information about Provider network participation.

We make no guarantee that a Participating Provider will be available for all services and supplies covered under your PPO coverage. For a limited number of services and supplies, We may not have arrangements with Participating Providers. Please call Our Member Service department for a list of the counties where We may not have Participating Providers for such services and supplies.

In some circumstances (excluding emergency services), We may require that you travel a reasonable distance for care within Our Provider network to receive services from a Participating Provider. If you knowingly choose to obtain the service from a Non-Participating Provider rather than the Participating Provider, you will be responsible for paying any charges from the Non-Participating Provider that exceed the Maximum Allowed Amount except for Surprise Billing Claims. We will not deny or restrict Covered Services solely because you obtain treatment from a Non-Participating Provider; however, you may have a higher financial responsibility.

If We do not have a Participating Provider within a reasonable geographic distance for a Covered Service, you may be able to obtain an Authorized Service network exception so you may obtain care from a Non-Participating Provider at the In-Network benefit level. If you want to pursue a network exception to receive care for a Covered Service from a Non-Participating Provider at the In-Network level of benefits, you must call the Member Service department to request this exception prior to obtaining Covered Services from a Non-Participating Provider. If approved, We will pay the Non-Participating Provider at the In-Network level of benefits and you will not be required to pay more for the services than if the services had been received from a Participating Provider.

If you do not receive an Authorized Service network exception to obtain Covered Services from a Non-Participating Provider, the claim will be processed using your Out-of-Network cost shares.

If you need details about a Provider's license or training, or help choosing a Doctor who is right for you, call the member service number on the back of your Health Benefit ID card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Non-Participating Providers

Non-Participating Providers are those who have not signed any network agreements with Anthem. Services provided by non-Participating Providers are considered out-of-network. When Enrollees visit a non-Participating Provider they may have higher out-of-pocket expenses. Enrollees' out-of-network cost sharing responsibilities to non-Participating Providers can be found on the *Benefit Summary* under the heading "Out-of-Network."

In addition you are liable for a Non-Participating Provider's full billed charge for any non-Covered Service or services that exceed the Benefit Period maximum, except for Surprise Billing Claims

Anthem, on behalf of the Plan, will reimbursement directly to non-Participating Providers only when the Enrollee has authorized an assignment of benefits. Anthem requires a copy of the assignment of benefits for their records. If Anthem pays the Enrollee directly, the Enrollee will be responsible for paying the non-Participating Provider of services for all charges. These payments fulfill the Plan's obligation to the Enrollee for these services.

Cost Sharing Requirements

Cost Sharing refers to how the Plan and its Enrollees share the cost of health care services. It describes what the Plan is responsible for paying and what the Enrollee is responsible for paying. Enrollees meet their Cost Sharing requirements through the payment of copayments, deductibles, and coinsurance (as described herein) depending upon the terms of their benefits. Cost Sharing requirements depend upon the choices the Enrollee makes in accessing services. For example, if the Enrollee chooses to use a Participating Provider or Participating facility, the Enrollee's out-of-pocket expenses may be less than if the Enrollee or non-Participating Provider or non-Participating facility. The Enrollee's Cost Sharing requirements are based on the Maximum Allowed Amount.

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.

In their contracts, Participating Providers agree to accept Anthem's Allowed Amount as payment in full for Covered Services. Anthem determines a Maximum Allowed Amount for all procedures performed by Providers. The contracts between Anthem and its Providers include a "hold harmless" clause which provides that an Enrollee cannot be liable to the Provider for monies owed by Anthem for health care services covered under this Plan Document and Summary Plan Description.

Maximum Allowed Amount

This section describes how We determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by Participating and Non-Participating Providers is based on your plans Maximum Allowed Amount for the Covered Service that you receive. Please see BlueCard as described in the **ADMINISTRATIVE SERVICES** section of this Benefit Booklet under **How to File Claims** for additional information.

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

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

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges, except for Surprise Billing Claims. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you receive were not Medically Necessary. It means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

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

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the provider network for this specific health benefits program. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this plan is the rate the Provider has agreed with Us to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Member Service for help in finding a Participating Provider or visit www.anthem.com.

Providers who have not entered into a PPO Provider contract with Us are Non-Participating Providers.

For Covered Services you receive from a Non-Participating Provider, the Maximum Allowed Amount for this plan will be one of the following as determined by Us:

1. An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with Us, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

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

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

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

5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating provider will likely result in lower out of pocket costs to you. Please call Member Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

Member Service is also available to assist you in determining your plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Us to assist you, you will need to obtain from your Provider, the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out of pocket responsibility. Although Member Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

Member Cost Share

For certain Covered Services and depending on your health benefits program, you may be required to pay a part of the Maximum Allowed Amount as your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

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

We will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by the Provider for non-Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Both services specifically excluded by the terms of this Benefit Booklet and those received after benefits have been exhausted are non-Covered Services. Benefits may be exhausted by exceeding, for example, , the benefit caps or day/visit limits.

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

Authorized Services

In some circumstances, such as where there is no In-Network Provider or Participating Provider available for the Covered Service, We may authorize the In-Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Participating Provider. In such circumstance, you must contact Us in advance of obtaining the Covered Service. Please contact Member Service at the phone number as indicted on your ID card to request authorization.

Copayment

Copayments may be required for covered services. A Copayment is a predetermined, fixed-dollar amount an Enrollee must pay to receive a specific service. Enrollees are required to pay a Copayment to Providers for specific services as listed in the *Benefit Summary*. Enrollees are responsible for making Copayments directly to the Provider. Medical and Rx copayment amounts do apply to the out of pocket maximum. In addition to any Copayment required, Enrollees are responsible for any applicable deductible and/or coinsurance for additional services received, e.g., laboratory and X-ray services.

Deductible

A Deductible is a specified amount of expense for covered services that the Enrollee must pay within each Enrollee's Calendar Year before the Plan provides benefits. The Deductible amount is listed in the *Benefit Summary*.

There are two separate Deductibles: one for Participating Providers and one for Non-Participating Providers. Charges from a non-Participating Provider cannot be applied toward meeting the in-network Deductible, and charges from a Participating Provider cannot be applied toward meeting the out-of-network deductible. If a service, e.g., an office visit or inpatient hospital care, is subject to a Copayment, that service is not subject to the Deductible. However, additional services such as laboratory and X-ray services may be subject to the Deductible. Each Enrollee (up to two in a family) must meet a separate Deductible. A new Deductible is required for each Enrollee's Calendar Year. The out-of-network Deductible applies if the Enrollee chooses to receive services or supplies from a Non-Participating Provider.

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

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

Coinsurance/Out-of-Pocket Annual Maximum

Enrollees must first meet their required Deductible. After the Deductible is met in each Enrollee's Calendar Year, and after the Enrollee pays the required Copayment, the Plan pays a percentage of charges for Covered Services as listed on the *Benefit Summary*. This percentage is called Coinsurance.

Enrollees pay the Coinsurance percentage for Covered Services until the Out-of-Pocket Annual Maximum is reached for the Enrollee's Calendar Year. Until the Out-of-Pocket Annual Maximum is reached, the Plan pays the remaining percentage. Once the Out-of-Pocket Annual Maximum is reached, the Plan pays 100 percent of any remaining eligible charges, including Prescription drugs, for the remainder of the Enrollee's Calendar Year. The *Benefit Summary* details what charges count towards the Out-of-Pocket Annual Maximum.

NOTE: No one family member may contribute more than his individual coinsurance maximum toward meeting the family out-of-pocket annual maximum.

An Enrollee will always be responsible for the difference between billed charges and the Maximum Allowed Amount for Non-Participating Providers, even after reaching the Out-of-Pocket Annual Maximum for out-of-network services. The difference between Billed Charges and the Maximum Allowed Amount for Non-Participating Providers does not contribute towards your Out-of-Pocket Annual Maximum.

Some services are not subject to Coinsurance. The required Coinsurance percentages are listed on the *Benefit Summary*.

NOTE: The out-of-network Coinsurance limit applies to the Enrollee's choice of Participating Providers and Non-Participating Providers. However, if the Plan predetermines that there are no Participating Providers available and a network exception has been authorized, then the Participating level of benefits may apply as long as the service is Pre-authorized **prior** to services being received.

The Family Membership Out-of-Pocket Annual Maximum is also applicable for newborn and adopted children for the first 31-day period following birth or adoption if the child is enrolled or not enrolled following the 31-day period.

Benefit Period Maximum

Some Covered Services have a maximum number of days, visits or dollar amounts allowed under this Plan Document and Summary Plan Description during a Benefit Period. When the Deductible is applied to a Covered Service which has a maximum number of days or visits, the maximum benefits may be reduced by the amount applied to the Deductible, whether or not the Covered Service is paid by Us. These maximums apply even if the applicable Out-of-Pocket Annual Maximum has been satisfied. These maximums apply even if some or all of the claims first applied to satisfy the deductible.

Getting Approval for Benefits

We include the processes of Prior Authorization/Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization/Precertification: In-Network Providers must obtain Prior Authorization/Precertification in order for you to get benefits for certain services. Prior Authorization/Precertification criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may decide that a service that was first prescribed or asked for is not Medically Necessary if you have not tried other treatments which are more cost effective.

If you have any questions about the information in this section, you may call the member service phone number on the back of your Health Benefit ID Card.

Types of Requests

- **Prior Authorization/Precertification –** A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. Prior Authorization/Precertification is not required for emergent services; however you, your authorized representative or Doctor must tell us within 72 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Prior Authorization/Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination –** An optional, voluntary prospective or continued stay review request for a benefit coverage determination for a service or treatment. We will check your Booklet to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medically Necessary under this Booklet or is Experimental or Investigational as that term is defined in this Booklet.

- **Post Service Clinical Claims Review –** A retrospective review for a benefit coverage determination to decide the medical necessity or Experimental / Investigational nature of a service, treatment or admission that did not need Prior Authorization/Precertification and did not have a Predetermination review performed. Medical revieUs are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by Us.

Typically, In-Network Providers know which services need Prior Authorization/Precertification and will get any Prior Authorization/Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Prior Authorization/Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Prior Authorization/Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Prior Authorization/Precertification	
Services given by an In-Network Provider	**Services given by a BlueCard/Out-of-Network/Non-Participating Provider**
Provider	• Member must get Prior Authorization/Precertification. • If Member fails to get Prior Authorization/Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions, Prior Authorization/Precertification is not required. However, you, your authorized representative or Doctor must tell us within 72 hours of the admission or as soon as possible within a reasonable period of time.

How Decisions are Made

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, preventative care clinical coverage guidelines and other applicable policies and procedures to help make our medical necessity decisions, including decisions about Prescription Drug and Specialty Pharmacy Drug services. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time. Your Booklet and Master Contract take precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the Prior Authorization/Precertification phone number on the back of your Health Benefit ID Card.

We may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) if in our discretion, such change furthers the provision of cost effective, value based and/or quality services.

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

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

You may find out whether a Provider is taking part in certain programs by checking your on-line provider directory or contacting the member service phone number on the back of your Health Benefit ID Card.

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

Request Categories

- **Expedited –** A request for Prior Authorization/Precertification or Predetermination that, in the view of the treating Provider or any Doctor with knowledge of your medical condition, could; without such care or treatment, seriously threaten your life or health or your ability to regain maximum function; or subject you to severe pain that cannot be adequately managed without such care or treatment; or if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently.
- **Prospective –** A request for Prior Authorization/Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review -** A request for Prior Authorization/Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective -** A request for Prior Authorization/Precertification that is conducted after the service, treatment or admission has happened. Post Service Clinical Claims Reviewed by Us are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on applicable laws. Where applicable laws are stricter than federal laws, we will follow applicable laws. If you live in and/or get services in a state other than the state where your contract was issued other state-specific requirements may apply. You may call the phone number on the back of your Health Benefit ID Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Expedited Pre-Service Review	72 hours from the receipt of request
Non-Expedited Pre-service Review	15 calendar days from the receipt of the request
Expedited Concurrent/Continued Stay Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Expedited Concurrent/Continued Stay Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-expedited Concurrent/Continued Stay Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information we need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by applicable law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative

Important Information

We may, from time to time, waive, enhance, change or end certain medical management processes (including utilization management, case management, and disease management) and/or offer an alternate benefit if in Our sole discretion, such change furthers the provision of cost effective, value based and/or quality services.
We may also select certain qualifying Providers to take part in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.
Just because We exempt a process, Provider or Claim from the standards which otherwise would apply, it does not mean that We will do so in the future, or will do so in the future for any other Provider, claim or Member. We may stop or change any such exemption with or without advance notice.
You may find out whether a Provider is taking part in certain programs by checking your on-line Provider Directory, on-line pre-certification list or contacting the member services number on the back of your Health Benefit ID Card.

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

For benefits to be covered, Prior Authorization/Precertification will consider the following:

1. You must be eligible for benefits;
2. Premium, subscription charges or administrative fee must be paid for the time period that services are given;
3. The service or supply must be a Covered Service under your Plan;
4. The service cannot be subject to an Exclusion under your coverage;
5. You must not have exceeded any applicable limits under your coverage; and
6. You did not perform an act, practice, or omission that constitutes fraud or abuse when requesting the Prior Authorization/Precertification.

Health Plan Individual Case Management

Our health plan individual case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

Experimental or Investigational and/or Cosmetic Procedures

We don't pay for any services, procedures, surgeries or supplies that We consider Experimental or Investigational, and/or Cosmetic. In addition We don't pay for complications arising from any services, procedures, surgeries or supplies that We consider Experimental or Investigational, and/or Cosmetic.

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

Ongoing Care Needs

We coordinate ongoing care through services like continuity of care, case management and disease management.

Continuity of Care

If you are getting ongoing care for a medical condition when you first enroll in this coverage, We may be able to help ease the transition. Examples of ongoing care are prenatal/obstetrical care, Home Care or Hospice care. We try to avoid disruption of a new Member's care through Our transition of care policy. If interested, you or your Provider must review the reference sheet, complete a "Transition of Care Form" and submit them to Us for review. You or your Provider can get these materials by calling Our medical management department at 303-831-3238 or 1-800-797-7758.

Health Care Individual Case Management

Our health plan individual case management programs (Case Management) help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen authorized representative, treating Doctor(s), and other Providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a Covered Service. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the Member and Anthem Blue Cross and Blue Shield. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify you or your authorized representative in writing.

The BlueCard Program

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

If you are out of state and an Emergency or urgent situation arises, go to the nearest Emergency or Urgent Care Facility.

In a non-Emergency situation, you can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of your Health Benefit ID Card.

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

Care Outside the United States – Blue Cross Blue Shield Global Core® Program

Before you travel outside the United States, check with your Group or call Member service at the number on your Identification Card to find out if your plan has **Blue Cross Blue Shield Global Core® Program** benefits. Your coverage outside the United States may be different and Anthem suggests:

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

Call the Service Center in these non-emergency situations:

- You need to find a Doctor or Hospital or need health care. An assistance coordinator, along with a medical professional, will arrange a Doctor visit or Hospital stay, if needed.
- You need Inpatient care. After calling the Service Center, you must also call Anthem to get approval for benefits at the phone number on your Identification Card. Note: this number is different than the phone numbers listed above for **Blue Cross Blue Shield Global Core® Program.**

Payment Details

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

Claim Filing

- The Hospital will file your claim if the **Blue Cross Blue Shield Global Core® Program** Service Center arranged your Hospital stay. You will need to pay the Hospital for the out-of-pocket costs you normally pay.

- You must file the claim for outpatient and Doctor care, or Inpatient care not arranged through the **Blue Cross Blue Shield Global Core® Program** Service Center. You will need to pay the Provider and subsequently send an international claim form with the original bills to Us.

Claim Forms

You can get international claim forms from Anthem, the **Blue Cross Blue Shield Global Core® Program** Service Center, or online at www.bcbsglobalcore.com... The address for sending in claims is on the form.

Eligibility

Employee Participants

An Employee is one who works at least 30 hours per week (full-time employment status) directly in the regular business of and is compensated for services by the Member or Member Affiliated Entity. Elected officials, except for non-salaried elected officials and Licensed Professional Elected Officials, are considered Employees under the Plan. At the option of the Member, permanent part-time and/or any other employees that qualify under the Affordable Care Act working a minimum of 24 hours per week, and Licensed Professional Elected Officials may be eligible for coverage; in such case, such qualified part-time Employees and Licensed Professional Elected Officials are considered Employees under the Plan. Also, at the option of the member, employees that are participants in a retirement incentive program provided through the member, and who are between 62 and 65 years of age with a minimum of 5 consecutive years of employment service, may be eligible for coverage; in such case, Incentivized Retirees are considered Employees under the Plan. Incentivized Retirees eligibility for coverage would be limited to coverage starting as early as the month in which they become 62 years of age and ending at the end of the month in which they become 65 years of age. Temporary Employees and retirees are not eligible and cannot be considered for coverage. Eligibility for coverage as an Employee Participant in the Plan begins subsequent to the day a person commences either full-time or qualifying part-time employment, in accordance with individual policies set by Members.

Suspension or denial of eligibility, coverage, and benefits may occur should an Employee Participant fail to do any of the following:

- Pay required contribution, if any, to the Plan.
- Furnish any information, records or releases that the Plan may require in order to adjudicate a claim.
- Cooperate with the procedures and investigations of the Plan.
- Meet the requirements of the Plan Document and Summary Plan Description.
- Meet the definition Employee as stated above.

Employee Participants may be entitled to benefits under the Plan during a family or medical leave in accordance with the provisions of the Family and Medical Leave Act of 1993, as may be amended.

Temporary Employees may be eligible for the plan in accordance with the provisions of the Member's Affordable Care Act Look Back Policy.

Employee Participant's Dependents

Your group may have limited or excluded the eligibility of certain Dependent types and so not all Dependents listed in this Plan may be entitled to enroll. For more specific information, please see your Human Resources or Benefits Department.

An Employee Participant's Dependents may include the following:

- An Employee Participant's legal spouse, common-law spouse (unless legally separated), civil union or same-sex domestic partner
- An Employee Participant's Dependent child (including a step-child, legally adopted or disabled child) under 26 years of age. At the end of the birth month in which the child attains turns age 26, the Dependent child is removed from coverage. If the Subscriber or the Subscriber's Spouse is subject to a qualified medical child support order for a Dependent child of the Subscriber or the Subscriber's Spouse, the Dependent child is eligible for benefits, whether the child lives with the Subscriber or the Subscriber's Spouse. The dependents (spouse or child) of a Dependent child are not eligible for coverage under this Plan Document.
- Coverage may be continued for any unmarried Dependent child after the age of 26 if incapable of self-support because of mental retardation or severe physical handicap, provided such Dependent child became so incapable prior to the end of the month in which the child attained the limiting age and is dependent upon the Employee Participant for care and support. Notification and a Physician's statement certifying such incapacity must be submitted to the Plan within 31 days of the date the Dependent child's coverage would otherwise terminate.
- If both husband and wife are employed by the same Member and are eligible as Employee Participants, either Employee spouse may elect to cover the other Employee spouse as a Dependent together with any eligible children.

- Proof of dependent status or legal guardianship may be requested from time to time by the Plan. This proof may be requested in the form of marriage records, birth certificates, and official court certified adoption, legal guardianship and divorce decree documents. A Power of Attorney will not be accepted as proof of dependency.
- The Employee Participant must notify the Member and the Plan within 31 days after any change in status affecting coverage resulting from marriage, birth, adoption, divorce, legal separation, death, a child reaching age 26, or the entrance into or the return from military service.
- Eligibility for Employee Participants and Dependents is additionally limited to persons who are United States citizens by birth or naturalization, or who are legal aliens lawfully residing in the United States.

Employee Participant's Disabled Dependent(s)

Benefits under this Plan for an unmarried Dependent child may be continued if all of the following tests are met:

- The child is incapable of self-sustaining employment because of mental retardation or physical handicap and became so incapacitated prior to such date.
- The child is chiefly dependent on the Employee Participant for support.
- The Member and the Plan are furnished proof of the incapacity not later than 31 days after the date the child attains age 26.

However, benefits as to such child may not be continued beyond the earliest of the following occurrences:

- Cessation of the incapacity.
- Failure to furnish any required proof of continuing incapacity or to submit to any required examination.
- Termination of the child's coverage for any reason other than age.

The Plan has the right to require proof of the continuation of incapacity and the right and opportunity to examine the child as often as is reasonably necessary during the continuation of the incapacity. However, an examination will not be required more often than once a year. The "Mentally or Physically Disabled Dependent Enrollment Request" is available from the Plan or Member Service and must be completed by a physician with the appropriate medical specialty.

Medicare Eligible Enrollees

Before an Employee Participant becomes age 65, or if an Employee Participant qualifies for Medicare benefits through other circumstances, the Employee Participant is responsible for contacting the local Social Security Administration office to establish Medicare eligibility.

- If an Employee Participant qualifies under the provisions of Federal Law for the working aged, then the Employee Participant age 65 and older and/or the Employee Participant's spouse age 65 or older may continue coverage under this health care coverage. If a working aged eligible Medicare beneficiary enrolls with Medicare and requests Medicare as primary coverage, this Plan will not provide benefits complementary to Medicare. (The Coordination of Benefits provision will not apply.). Special Medicare Secondary Payer (MSP) rules apply if an Enrollee is receiving benefits from Medicare due to a disability or end-stage renal disease. The Enrollee must contact the Member Service for more information and for eligibility guidelines regarding Medicare eligibility.
- If the Employee Participant or Spouse elects the benefits of this Plan as primary, the Plan will provide benefits equivalent to the benefits available to individuals not eligible for Medicare.
- If the Employee Participant or Spouse elects Medicare as primary, this Plan will not provide benefits complementary to Medicare. The Coordination of Benefits provision will not apply.
- If an Employee Participant, or the Dependent of an Employee Participant, is eligible for Medicare because of a total disability, this Plan will provide benefits unless the Employee Participant has declined to enroll in the Plan. This Plan will not provide benefits complementary to Medicare. The Coordination of Benefits provision will not apply.
- When an Employee Participant, or the Dependent of an Employee Participant, is eligible for Medicare because of permanent kidney failure (end stage renal disease), the Plan will provide primary benefits for the first 30 months. Thereafter, the Plan's benefits will be payable to the extent that those charges are not covered under Medicare. The Coordination of Benefits provision will apply.
- Any Covered Person who is eligible for Medicare Part A because of permanent kidney failure (end stage renal disease) shall be considered covered under Medicare Part A whether or not actually covered thereunder.
- Any Covered Person who is eligible for Medicare Part B because of permanent kidney failure (end stage renal disease) shall be considered covered under Medicare Part B whether or not actually covered thereunder.
- For any COBRA Enrollee covered under this Plan pursuant to COBRA coverage who first becomes enrolled in either Part A or Part B of Medicare prior to the date of COBRA election, benefits under this Plan will be payable to the extent that Eligible Expenses are not covered by Medicare. The Coordination of Benefits provision will apply. This paragraph does not apply to COBRA Enrollees eligible for Medicare because of permanent kidney failure (end stage renal disease).
- **Note: The Enrollee must notify the Plan of election of Medicare as primary and notification must be <u>in writing</u>**.

Effective Dates and Contribution Requirements

This Plan Document and Summary Plan Description is effective as of January 1, 2022. Benefits of this Plan shall be payable only for expenses incurred on or after the Effective Date of this Plan Document and Summary Plan Description, and on and after the Effective Date for an Enrollee's coverage, except as specified.

The Effective Date for an Enrollee's coverage under the Plan will commence on the first of a month, the waiting period is determined in accordance with a policy set by the individual Member that employs the prospective Employee Participant. Plan Members have elected whether their individual Employee Participants will contribute to the cost of the Employee Participants' and/or Dependents' coverage.

Benefits for Employee Participants

- Coverage for the Employee Participant becomes effective on his eligibility date provided the Employee Participant has enrolled and authorized contributions (if required). If the Employee Participant enrolls within 31 days of his eligibility date, coverage will be effective on the date of eligibility.
- If the Employee Participant does not enroll within 31 days of his eligibility date, or coverage is terminated at any time while the Employee Participant is still at work, he is considered to be a Late Enrollee. If he was covered under another plan and loses that coverage, he may be eligible for Special Enrollment. He may, in the future, be able to enroll himself in this Plan effective January 1 of an open-enrollment year, provided that he requests enrollment prior to January 1 of the year he desires coverage.
- If the Employee Participant does not want coverage, he must sign a waiver of benefits.

Benefits for Dependent Participants

Coverage for Dependent Participants becomes effective on the date eligible provided the Employee Participant has enrolled and authorized contributions (if required) for Dependent benefits on or prior to the date eligible.

- If an Employee Participant has eligible Dependents on the Effective Date of his coverage and he has enrolled and authorized contributions (if required) for Dependent benefits, coverage for those Dependents will be effective on the date the Employee Participant's coverage begins.
- If an Employee Participant, who is not required to contribute toward the cost of Dependent benefits, does not have eligible Dependents on the Effective Date of his coverage and later acquires his first eligible Dependent(s) and enrolls his Dependent(s) within 31 days of the date eligible, coverage will be effective on the date of acquisition.
- If an Employee Participant, who is required to contribute toward the cost of Dependent benefits, does not have eligible Dependents on the Effective Date of his coverage and later acquires his first eligible Dependent(s), enrolls his Dependent(s) within 31 days of the date eligible, and authorizes contributions for Dependent benefits to be effective the date of acquisition, coverage will be effective on the date of acquisition.
- If an Employee Participant, who is required to contribute toward the cost of Dependent benefits, does not have eligible Dependents on the Effective Date of his coverage and later acquires his first eligible Dependent(s), enrolls his Dependent(s) within 31 days of the date eligible, and authorizes contributions for Dependent benefits to be effective the first of the month following acquisition, coverage will be effective on the first of the month following acquisition.
- Dependent benefits with respect to a Dependent acquired by an Employee Participant while he is covered for Dependent benefits shall become effective on the date such Dependent is acquired if he enrolls his Dependent within 31 days.
- If an Employee Participant does not enroll for Dependent benefits within 31 days of the date eligible or Dependent coverage is terminated at any time while the Employee Participant is still at work, his Dependent(s) are considered to be late Enrollee(s). If they are covered under another plan and lose that coverage, they may be eligible for Special Enrollment. The Employee Participant may in the future be able to enroll his Dependent(s) in this Plan effective January 1 of an open-enrollment year, provided that he requests enrollment **prior** to January 1 of the year they desire coverage.
- In the case of a newborn Dependent, coverage will be retroactive to the date of birth. The first 31 days, the newborn will be covered under the mother's policy, if a covered participant of the plan. To extend coverage for the newborn beyond the first 31 days, the Employee Participant must enroll the newborn within 31 days following the birth.
- If the Employee Participant does not want coverage for his eligible Dependents, he must sign a waiver of benefits.

- No Dependent benefits shall become effective unless the Employee Participant is, or simultaneously becomes an Enrollee covered for benefits.

Enrollment Process

In order for eligible Employee Participants and their eligible Dependents to obtain benefits, the Employee Participant must follow the Member's enrollment process, which details who is eligible for enrollment and what forms are required for enrollment. Eligibility for benefits under this Plan Document and Summary Plan Description begins as of the Effective Date stated on the benefit ID Card. No services received prior to that date are covered.

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

Enrollment Forms

The Employee Participant must submit an Enrollment Application/Change Form to add any Dependents as Enrollees. Additional forms may be required for special dependent status. Employee Participants may obtain an Enrollment Application/Change Form or any additional forms from their CHP Benefit Administrator/Contact Person.

Initial Enrollment

Eligible Employees may apply for benefits for themselves and their eligible Dependents by submitting an Enrollment Application/Change Form. The Member and the Plan must receive the Enrollment Application/Change Form within 31 days after the date of hire or within 31 days of the expiration of the waiting period, as defined in the Member's new hire policy. The Effective Date of benefits will be determined in accordance with any established waiting period as determined by the Member. The Member will inform the Employee of the length of the waiting period or applicable Look Back Period.

Open-enrollment

Any eligible Employee may enroll during the Plan's open-enrollment period. The Benefit Administrator/Contact Person will provide the dates of the open-enrollment period to eligible Employees.

Newly Eligible Dependent Enrollment

A current Employee Participant may add a Dependent, for whom the Employee Participant is legally financially responsible regarding medical, dental, and other health care expenses, that becomes newly eligible due to a Qualifying Event. See the *Employee Participant's Dependent* heading in this section for information on eligibility requirements of a Dependent. Qualifying Events may include marriage, birth, placement for adoption, issuance of a court order, loss of Medicaid, Colorado Health Insurance Program coverage or eligibility for state premium assistance. The Member and the Plan must receive an Enrollment Application/Change Form for the addition of the Dependent within 31 days after the date of the Qualifying Event (60 days for a Qualifying event defined as a loss of Medicaid, CHIP coverage or eligibility for state premium assistance). 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. Eligibility for benefits will be effective as described in the *Employee Participant's Dependent* section.

When the Employee Participant or the Employee Participant's spouse is required by a court or administrative order for child support, to provide coverage for an eligible Dependent, the eligible Dependent must be enrolled within 31 days of the issuance of such order. The Member and the Plan **must** receive a copy of the court or administrative order with the Enrollment Application/Change Form. If the Employee Participant does not enroll the eligible Dependent within 31 days of issuance of the order, the Employee Participant may in the future be able to enroll his Dependent(s) in this Plan effective January 1 of an open-enrollment year, provided that he requests enrollment **prior** to January 1 of the year they desire coverage..

Special Enrollment for Eligible Employees and Eligible Dependents

If the Employee Participant does not enroll within 31 days of his Eligibility Date, or coverage is terminated at any time while the Employee Participant is still at work, he is considered to be a *Late Entrant* unless he was covered under another plan and loses that coverage, in which case he may be eligible for Special Enrollment. He may in the future be able to enroll himself and his eligible Dependents in this Plan during the open-enrollment period.

Late Entrants

Status Change of State Medicaid Plan or State Child Health Insurance Program (SCHIP)

Loss of eligibility from a state Medicaid or SCHIP health plan is also a qualifying event for special enrollment for the eligible employee and/or eligible Dependents. The employee must properly file an application with the employer within 60 days after coverage has ended, Medicaid coverage has ended, or 90 days after SCHIP coverage has ended. In addition, special enrollment is allowed for the employee who becomes eligible for premium assistance, with respect to coverage under the employer's health coverage, under a state Medicaid or SCHIP health plan, including any waiver or demonstration project conducted under or in relation to these plans. Similarly, the employee must properly file an application with the employer within 60 days after the eligibility date for assistance is determined.

Military Service

Enrollees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to employees and their Dependents covered under the Plan before the employee leaves for military service:

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

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

Termination

Employee Participant Termination

The coverage of any Employee Participant under this plan shall cease on the earliest of the following:

- The termination date of this Plan Document and Summary Plan Description.
- The ending of the period for which contributions, if required, have been paid.
- The last day of the month the Employee Participant is no longer eligible for coverage under this Plan Document and Summary Plan Description.
- The Employee Participant begins active duty in the Armed Forces of any country for longer than 31 days.
- The death of the Employee Participant.
- The last day of the month the Employee Participant terminates employment.
- The last day of the month in which retirement of the Employee Participant occurs,unless covered as an Incentivized Retiree
- The last day of the month in which an Employee Participant has experienced a Qualifying Event or financial hardship. The Employee has 31 days from the date of the Qualifying Event or financial hardship to notify the Plan Administrator and provide supporting documentation.

A Member must signify an Employee's termination of employment by notifying the Plan. If subsequent to termination of service, an Employee Participant is re-employed or reinstated as an eligible Participant, he will be treated in the same manner as a new Participant at the date of such re-employment or reinstatement unless such Employee Participant has been covered continuously since termination by electing coverage under this Plan through COBRA.

Members may, according to their policies, continue coverage for an Employee Participant on leave of absence or otherwise approved absence from work, at the same contribution level as any other Employee for a period of up to six months without terminating the Employee Participant.

Employee Participant's Dependent Termination

Coverage with respect to any participating Dependent shall cease at the end of the month in which the individual ceases to be a Dependent as defined in this Plan Document and Summary Plan Description. Coverage with respect to all Dependents of an Employee Participant shall cease on the date coverage terminates for the Employee, except as provided in COBRA COVERAGE as defined in this document. An Employee Participant's Dependent coverage shall also terminate at the end of the month the Employee Participant requests such coverage be terminated, but in no event prior to the date of such request.

Effect of Termination

When coverage terminates, benefits shall not be provided for any hospital or medical service after termination even though such services are furnished as a result of a sickness or accident occurring before such termination of coverage unless otherwise provided under this plan.

What the Plan Will Pay for After Termination

The Plan will not pay for any services provided after the Enrollee's benefits end. An Enrollee is liable for benefit payments made by the Plan on behalf of the Enrollee for services provided after the Enrollee's benefits have terminated, even if the termination was retroactive.

Rescission

The County Health Pool will not rescind individual coverage, other than for failure to pay premiums in a timely manner, unless there is fraud or an individual makes an intentional misrepresentation of material fact.

COBRA Coverage

In accordance with Federal Law, under certain circumstances, an Enrollee whose coverage under this Plan would otherwise terminate may elect to continue coverage for a limited period of time.

An Enrollee who is eligible for COBRA coverage is called a Qualified Beneficiary. The events making an Enrollee eligible for COBRA coverage are called Qualifying Events. Definitions of both terms can be found in the GLOSSARY section.

COBRA Eligibility

Employee Participants and their Dependents who lose eligibility under this Plan are eligible for COBRA coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, including without limitation amendments under the American Recovery and Reinvestment Act of 2009 ("ARRA") and subsequent legislation Enrollees should contact their Benefit Administrator/Contact Person for additional information. COBRA coverage is available for 18, 29 or 36 months, depending on the Qualifying Event(s), and only if the application and premium of the Federal Law are met.

COBRA coverage is available for Employee Participants and their Dependents for 18 months from the date of the following Qualifying Events:

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

COBRA coverage is available for Employee Participants and their Dependents for 29 months from the date of the following Qualifying Event:

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

COBRA coverage is available for the following individuals for 36 months from the date of the following Qualifying Events:

- The surviving spouse and surviving children of a covered Employee Participant, when the covered Employee Participant dies.
- The Employee Participant became eligible for Medicare benefits prior to COBRA election.

- Spouse or dependent children of a covered employee, if the employee became eligible for Medicare benefits before COBRA election.
- Spouse or dependent children of a covered employee, when the employee and the Spouse separate or divorce.
- Spouses and dependent children of a covered Employee Participant, when the dependent children lose eligibility as Dependents.

COBRA coverage is available to children born or placed for adoption during the period of COBRA coverage for the remainder of either the 18-month or 36-month COBRA continuation period. The Qualifying Event that triggered the COBRA coverage will determine the length of the continuation period for the newborn or adoptee.

COBRA Notification

In the case of a Qualifying Event (death, termination of employment or reduction in hours) a Qualified Beneficiary will receive information from the Plan concerning COBRA coverage within 14 days of loss of coverage. This information will include instructions on how to elect COBRA coverage, the amount of the monthly COBRA contribution, and enrollment and payment instructions. With respect to disabled Employees electing the 11-month extension of COBRA coverage, such disabled Employee must notify the Plan within 60 days of determination of disability by Social Security and before the end of the initial 18-month continuation period. In addition, the disabled Employee must notify the Plan within 30 days of final determination of Social Security that the disability no longer exists. Following receipt of timely notice of such Qualifying Event and within 14 days of receipt of such notice, the Plan will provide the disabled Employee with information concerning COBRA coverage and rates.

In the case of a Qualifying Event, or the Employee's enrollment in either Part A or Part B of Medicare, a Qualified Beneficiary must notify the Member and the Plan within sixty 60 days of the Qualifying Event. If notice is not received within 60 days of the Qualifying Event, the Qualified Beneficiary will not be eligible for COBRA coverage. Following receipt of timely notice of a Qualifying Event and within 14 days of loss of coverage, the Plan will provide the eligible Dependent with information concerning COBRA coverage and rates.

After notification of COBRA coverage, the Qualified Beneficiary will have 60 days to elect COBRA coverage, after the later of the following dates:

- The date that the Qualified Beneficiary would lose coverage on account of the Qualifying Event,
- The date that the Qualified Beneficiary is sent such notice.
- If a Qualified Beneficiary chooses to waive coverage, a waiver of COBRA coverage will be effective on the date that the waiver is sent to the Plan.
- A Qualified Beneficiary who, during the election period, waives COBRA coverage can revoke the waiver at any time before the end of the election period. However, if a Qualified Beneficiary who waives COBRA coverage later revokes the waiver, coverage will be effective retroactive to the original Qualifying Event date.
- The first monthly payment (which will include premiums for all months since coverage terminated) must be received by the Plan within 45 days of the date the Qualified Beneficiary elects to continue coverage. Each subsequent payment is due by the first day of the month for which coverage is intended, and shall be considered timely if received within 30 days of the date due.
- If premiums are not received in a timely manner, coverage will terminate as the first day of any period for which timely payment is not made to the plan. No claims will be paid until premium payment is received by the Plan.

Termination of COBRA coverage

COBRA coverage as provided under this section will terminate on the earliest of the following dates, as applicable:

- The date the Qualified Beneficiary first becomes covered under any other group medical coverage as an Employee or Dependent after COBRA is elected. In the event such other group medical coverage has a pre-existing condition clause or limitation, COBRA coverage will not terminate until exhaustion of the maximum period COBRA coverage is allowed or until the pre-existing condition clause or limitation has been satisfied.
- The end of the period for which the last payment was made for coverage in a timely manner.
- The maximum continuation period has been exhausted.
- The date the spouse remarries and becomes eligible for coverage under the new spouse’s policy of group health insurance.
- The date the Qualified Beneficiary first becomes enrolled in either Part A or Part B of Medicare after COBRA is elected, other than as an ESRD beneficiary.
- The date the Member ceases to provide any group medical plan.

- The Qualified Beneficiary's coverage was extended due to disability and there has been a final determination that he is no longer disabled. In that case, COBRA coverage for all Qualified Beneficiaries who were entitled to the disability extension, by reason of the disability of the Qualified Beneficiary who has been determined to be no longer disabled, will end on the first day of the month that begins no more than 30 days after the date of final determination that the individual is no longer disabled. Such determination will not result in the termination of COBRA coverage before the end of the maximum coverage period that would apply without regard to the disability extension.
- The end of the month for which the Qualified Beneficiary has requested, **in writing**, a voluntary termination.

Contribution for COBRA coverage

For a Qualified Beneficiary to continue coverage under this Plan, the entire cost of coverage must be paid to the Plan each month. The contribution amount will be 102% (except in the case where COBRA is extended due to disability, the contribution amount will be 150%) of the applicable contribution for a similarly situated non- COBRA Enrollee.

Election Period for COBRA coverage

A Qualified Beneficiary must elect COBRA coverage within sixty (60) days after the later of:

- The date coverage terminates under this Plan because of the Qualifying Event.
- The date the Qualified Beneficiary receives notice from the Plan of the right to this Continuation.

Under certain circumstances, COBRA amendments may provide for premium reductions or extended election periods for health benefits under COBRA. If applicable, notice thereof will be provided as required by law.

Further detail concerning COBRA is available from the Benefit Administrator/Contact Person.

Family and Medical Leave Act

When an Employee Participant takes time off from work pursuant to the Family and Medical Leave Act, medical benefits remain in force but the Employee Participant may be required to pay the Member's share of the contribution. Enrollees may contact their Benefit Administrator/Contact Person for details.

Covered Services

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 Plan Document and Summary Plan Description as determined by Anthem, on behalf of the Plan, and obtained in the manner required by this Plan Document and Summary Plan Description. 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. For services received from a non-Participating or out-of-state Provider, the Enrollee is responsible for verifying that Pre-certification/Pre-authorization required for certain services is obtained. This information is available by calling Member Service. Anthem bases its decisions about Pre-certification/Pre-authorization, 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.

Care must be received from a Participating Provider to be covered at the In-Network level, except Pre-certification/Pre-authorization. Services which are not received from a Participating Provider will be considered Out-of-Network, unless otherwise specified in this Plan Document

All covered services are subject to the exclusions listed in this section in addition to those set forth elsewhere in this Plan Document and Summary Plan Description including those in GENERAL EXCLUSIONS in this document. All covered services are subject to the other conditions and limitations of this Plan Document and Summary Plan Description.

Preventive Care Services

This section describes covered services and exclusions for preventive care.

Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

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

In-Network Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services when provided by Participating Providers are covered by this Plan Document with no Deductible, Copayment or co-insurance.. That means that we pay 100% of the Maximum Allowed Amount for Participating Providers. Most Preventive Care Services when received Out-of-Network are not covered, see information below for those services that are covered. In-Network Covered Services fall under the following broad categories as shown below:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:

- Breast cancer;
- Cervical cancer;
- Colorectal cancer;
- High Blood Pressure;
- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child and Adult Obesity.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

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

4. Other preventive care and screening for women are also covered based on the guidelines from by the Health Resources and Services Administration, including the following:

  – Women's contraceptives, sterilization procedures, and counseling. This includes Generic and Single Source Drugs as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intrauterine devices (IUDs), and implants are also covered. You must get covered contraceptives from an In-Network pharmacy or Participating Provider, if you don't they will not be covered. Multi-Source Drugs will be covered as a Preventive Care benefit when Medically Necessary, otherwise they Drugs will be covered under the Prescription Drugs section.

  – Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.

  – Gestational diabetes screening.

- Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:

  – Counseling;

  – Prescription Drugs; and

  – Nicotine replacement therapy products when prescribed by a Provider, including over the counter (OTC) nicotine gum, lozenges and patches.

  Prescription drugs and OTC items are limited to a no more than 180 day supply per 365 days.

- Prescription Drugs and OTC items identified as an "A" or "B" recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

  – Aspirin;

  – Folic acid supplement;

  – Vitamin D supplement;

  – Iron supplement; and

  – Bowel preparations.

  – Please note that certain age and gender and quantity limitations apply

  Additional women's Preventive Care Services include well-woman visits, HPV testing, counseling for sexually transmitted infections, counseling and screening for HIV, and counseling and screening for interpersonal and domestic violence.You may call Member Service using the number on your ID card or your CHP Benefits Administrator for additional information about these services. (or view the federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html; or http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/.)

  Covered Services also include the following services required by state law:

- Routine screening mammogram;
- Routine cytologic screening (pap test);
- Routine prostate specific antigen (PSA) blood test and digital rectal;
- Colorectal cancer examination, including colonoscopies and related laboratory tests;
- Routine PKU tests for newborns.
- Cholesterol screening for lipid disorders;
- Tobacco use screening of adults and tobacco cessation interventions by your Provider;
- Alcohol misuse screening and behavioral counseling interventions for adults by your Provider.

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

In addition to federal and state law requirements, the following services are covered for both men and women over the age of 19

- Annual medical diabetes eye exams, or in accordance with the frequency determined by your Provider;
- 1 Department of Transportation Commercial Driver's License (DOT-CDL) physical every 24 months (if required for job with Member). An additional DOT-CDL physical required to maintain the CDL for the Members job within 12 months based upon a medical condition will be covered in addition to the 24 month CDL.
- 1 Biennial Occupational Firefighter Medical Evaluation. Reimbursement limit capped at the current CDL level of reimbursement.
- Services received at a community-based health fair, maximum reimbursement of $40 total per year. Submit claims to Anthem, on behalf of the Plan, for reimbursement. PSA testing done at the health fair covered at in-network coinsurance levels.
- An annual flu immunization

Out-of-Network preventive care is covered for the following services:

Children

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

All children age 0-12 years

- Routine immunizations, including an annual flu immunization*

Age 0-11 Months

- 6 well-child visits
- 1 PKU (phenylketonuria) test

Age 12-23 Months

- 3 well-child visits

Age 2-6 years

- 1 well-child visit every year*

Age 7-13 years

- 1 well-child visit every two years*
- Immunizations against cervical cancer to the extent required by applicable law

Women

Age 40 years and over

- 1 mammogram every year.*

Men

Age 40 years and over

- 1 prostate specific antigen (PSA) blood test and digital rectal examination every year.* When a PSA is received at a community-based health fair, you are required to pay in-network coinsurance.

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

- Out-of-Network preventive care visits that exceed the limits listed above for children up to age 13.
- Routine exams and immunizations related to sports, insurance, condition of employment (except DOT-CDL exam every 24 months), for licensing, school, church or camp.
- Immunizations required for travel.
- Preventive services provided Out-of-Network except as provided above as covered service.

* Provided at anytime within the current plan year

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 Provider'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 and birth control patches provided under the heading of PRESCRIPTION DRUGS.

Benefits are also provided for:

- 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 purposes (e.g., sponges, spermicides and condoms).
- Reversals of sterilization.

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.

Maternity and Newborn Care

This section describes covered services and exclusions for maternity and newborn care.

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

Benefits are provided for:

- Inpatient, outpatient, midwife and physician office services (including prenatal care) for vaginal delivery, cesarean section, and complications of pregnancy.
- Anesthesia services.
- Routine nursery care for a covered newborn including Provider services.
- For covered newborns all medically necessary care and treatment of injury and sickness including medically diagnosed congenital defects and birth abnormalities.
- Circumcision of a covered newborn male.
- Laboratory services related to prenatal care, postnatal care or therapeutic termination of a pregnancy.

- **One routine ultrasound per pregnancy**. Additional ultrasounds are based on medical necessity and require Pre-certification/Pre-authorization. See the *Managed Care Features* heading in the ABOUT YOUR HEALTH COVERAGE section for information on Pre-certification/Pre-authorization guidelines.
- Therapeutic termination of pregnancy is a benefit only when necessary to prevent the death of the pregnant Enrollee and every reasonable effort has been made to preserve her and her unborn child's lives. The procedure must be performed in a hospital or other licensed healthcare facility. There must be documentation that the Enrollee has a medical condition, as determined by a licensed physician Provider, which represents a serious and substantial threat to the life of the pregnant Enrollee if the pregnancy is allowed to continue to term.

Anthem, on behalf of the Plan, will not limit benefits for a hospital stay in connection with childbirth for the mother and newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. If the delivery occurs between 8:00 p.m. and 8:00 a.m., and the 48 or 96 hours have passed, benefits will continue until 8:00 a.m. the following morning. The mother's attending physician, after consulting with the mother, may discharge the mother and newborn child earlier if appropriate.

The newborn child must be the child of the Employee Participant or the Employee Participant's spouse to be eligible for benefits. If the mother of the newborn child is a covered Dependent child of the Employee Participant, only the mother's services are covered benefits. Any services the newborn child receives are not covered benefits. To learn how to enroll the newborn child of a Dependent child within 31 days of birth, see the *Employee Participant's Dependents* heading in ELIGIBILITY in this document for information.

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

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

Diabetes Management

This section describes covered services and exclusions for diabetic management.

Benefits are provided to Enrollees 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, glucose monitor and diabetic eye exams. Training and education are covered throughout the Enrollee's disease course when provided by a Certified, registered, or licensed health care professional with expertise in diabetes. Insulin pumps and related supplies are covered subject to meeting Anthem's medical policy criteria. Diabetic supplies and equipment are subject to the annual benefit maximum for durable medical supplies and equipment as listed in the *Benefit Summary*. When diabetic supplies are provided by a pharmacy they are covered under the prescription drug benefits and subject to the prescription copayment and do not apply to the medical equipment and supply benefit maximum.

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

- Diabetic equipment when received from an out-of-network Provider.

Physician Office Services

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

For preventive care refer to *Preventive Care Services* in this section. For family planning services, including maternity care, refer to *Family Planning* in this section. For diabetes treatment refer to *Diabetes Management* in this section. Refer to the section entitled *Mental Health and Substance Abuse Care* for those services covered by the Plan. To receive office services after hours, see the *Emergency Care and Urgent Care* section for information.

Benefits 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 Enrollee. In certain cases, Anthem, on behalf of the Plan, may request a second opinion.

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

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

- X-ray and other radiology services.
- Laboratory and pathology services.
- Ultrasound services for non-pregnancy related conditions. For pregnancy-related ultrasounds, see the *Maternity* section for information.
- Allergy tests, allergy injections and allergy serum.
- Audiometric (hearing) and vision tests required for the diagnosis and/or treatment of an accidental injury or an illness and for dependent children 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. For children up to the age of 18 see the *Hearing Aid Services* section for additional benefits.
- ADD and ADHD services.
- COVID-19 testing and treatment, as required under any applicable Federal Law.

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 Enrollees with diabetes).
-
- 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.

Inpatient Facility Services

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

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

Facility services

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

- Charges for semi-private room (with two or more beds), board, and general nursing services. Benefits are provided for the treatment of medical conditions and rehabilitation care, which is part of an acute care hospital stay.
- Use of operating room, recovery room and related equipment.
- Medical and surgical dressings, supplies, surgical trays, casts and splints when supplied by the facility as part of an inpatient admission.
- Prescribed drugs and medicines administered as part of an inpatient admission.

- A room in a special care unit approved by Anthem, on behalf of the Plan. 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 for the primary purpose of restoring and/or improving lost functions following an injury or illness are limited to 31 days per the Enrollee's Calendar Year. Inpatient rehabilitation therapy may be received at an Acute Rehabilitation Facility, Skilled Nursing Facility, Long term Acute Care Facility or a Sub-acute Facility. Ancillary Services

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

- Diagnostic services such as laboratory and X-ray tests (e.g., CT scan, MRI).
- Chemotherapy and radiation therapy.
- Dialysis treatment.
- Respiratory therapy.
- Charges for processing, transportation, handling and administration of blood. 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, including 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 Enrollee's condition warrants.
- Surgical assistants or assistant surgeons as determined by Anthem's medical policy. The Plan 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 Enrollee's Provider.

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 an Enrollee chooses not to have surgical reconstruction after a mastectomy, the Plan will provide benefits for an external prosthesis. . This coverage will be provided in consultation with you and your attending physician and will be subject to the same Deductible, Coinsurance, Copayment provisions otherwise applicable under thePlan.For silicone breast implants, benefits are provided for the removal of the implant. Implants removed will not be replaced.

- This coverage provides benefits for many of the charges for transgender surgery (also known as sex reassignment surgery), where Medically Necessary as determined by our medical policies and guidelines. Covered Services must be approved by Us and must be authorized by Us prior to being performed. **Changes for services that are not authorized for the surgery requested will not be considered Covered Services. Some conditions apply, and all services must be authorized by us as outlined in the "How to Access Your Services and Obtain Approval of Benefits" section.**

Long Term Acute Care Facility

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

Skilled Nursing Facility

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

When skilled nursing care is Pre-authorized by Anthem, on behalf of the Plan, benefits are available for up to 30 days per Enrollee's Calendar Year or until maximum medical improvement is achieved and no further significant measurable improvement can be anticipated as determined by Anthem. Maximum medical improvement shall be determined without regard to whether continued care is necessary to prevent deterioration of the condition or is otherwise life sustaining. Pre-certification/Pre-authorization for admission and for continued stay is required by Anthem. See the *Managed Care Features* heading in ABOUT YOUR HEALTH COVERAGE in this document for information on Pre-certification/Pre-authorization guidelines.

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

- Room and board and related services in a nursing home.
- If the Enrollee leaves a hospital or other facility against the medical advice of the physician, the charges related to the non-compliance of care.
- 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 Enrollee's noncompliance with prescribed medical treatment.
- Procedures that are solely cosmetic in nature. See Anthem's medical policy at www.anthem.com for information on cosmetic services.
- Custodial and/or maintenance care.
- Any services or care for the treatment of sexual dysfunction.
- Sex change operations, preparation for a sex change operation, or complications arising from a sex change operation.
- Personal comfort and convenience items such as televisions, telephone, guest meals, articles for personal hygiene and other similar services and supplies.
- Surgical services for refractive keratoplasty, including radial keratotomy or lasik, or any procedure to correct visual refractive defect.
- Additional procedures that are routinely performed during the course of the main surgery.

Outpatient Facility Services

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

Refer to the section entitled *Mental Health and Substance Abuse Care* for those services covered by the Plan. 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 the Plan.

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 visit.
- Drugs and medicines when provided as part of an outpatient visit.

Ancillary Services

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

- Diagnostic services such as laboratory and X-ray tests (e.g., CT scan, MRI).

- Medical and surgical dressings, supplies, surgical trays, or cast and splints when provided in the outpatient department facility.
- Chemotherapy and radiation therapy.
- Dialysis treatment.
- Respiratory therapy.
- Charges for processing, transportation, handling and administration of blood. Blood and blood plasma is covered.
- Non-emergent injectables, IV therapies, and/or infusion medications administered in an outpatient setting or at home. These medications are not a covered benefit when obtained through any source other than Anthem's PBM.
- Ultrafast CT scan when preauthorized and allowed by Anthem's medical policy.

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 the Plan document for definitions of cosmetic services.
- Surgical assistants or assistant surgeons as determined by Anthem's medical policy. The Plan does not pay for a surgical assistant for all surgical procedures.
- Consultation by another physician when requested by the physician. Staff consultation required by facility rules is excluded.

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

- Surgical benefits for subsequent procedures to correct further injury or illness resulting from the Enrollee's noncompliance with prescribed medical treatment.
- Procedures that are solely cosmetic in nature.
- Any services or care for the treatment of sexual dysfunction.
- Sex change operations, preparation for a sex change operation, or complications arising from a sex change operation.
- Personal comfort and convenience items such as televisions, telephone, guest meals, articles for personal hygiene and other similar services and supplies.
- Surgical services for refractive keratoplasty, including radial keratotomy or lasik, or any procedure to correct visual refractive defect.
- Additional procedures that are routinely performed during the course of the main surgery.
- Peripheral bone density 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 dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. Urgent Care means situations that are not life threatening but require prompt medical attention to prevent serious deterioration in an Enrollee's health.

The Plan covers Emergency services necessary to screen and stabilize an Enrollee without Pre-certification/Pre-authorization 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**. If you continue to get care from an Out-of-Network Provider, Covered Services will be covered at the Out-of-Network level unless we agree to cover them as an Authorized Service network exception.by choosing an Urgent Care center when available and appropriate instead of an Emergency room, the Enrollee may reduce out-of-pocket expenses.

Emergency Care

Medically Necessary Emergency care includes Emergency accident care and Emergency medical care received at a hospital or other facility. Benefits are provided regardless of whether the care is received from a Participating Provider or a non-Participating Provider. No prior authorization is necessary. An Enrollee should call 9-1-1 in the case of a life or limb-threatening Emergency.

Whenever an Enrollee is admitted to a facility directly from a hospital Emergency room, the Emergency room copayment will be waived, however the inpatient hospital copayment will apply to the admission. When an Enrollee is admitted to a facility following Emergency care **Anthem, on behalf of the Plan, 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 Enrollee 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 Enrollee is stabilized, ongoing care and treatment is not Emergency Care. Continuation of care from a Participating Provider or a non-Participating Provider beyond what is needed to evaluate and/or stabilize the Enrollee's condition will be considered out-of-network care and paid subject to the out-of-network payment provisions.

As described in the "Consolidated Appropriations Act of 2021 Notice", Out-of-Network Providers may only bill you for any applicable Copayments, Deductible, and Coinsurance and may not bill you for any charges over the Plan's Maximum Allowed Amount until the treating Out-of-Network Provider has determined you are stable. Please refer to the notice following the Schedule of Benefits for more details

Urgent Care

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

Travel outside the country

In an Emergency or Urgent Care situation the Enrollee should go to the nearest health care facility. The Enrollee 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 Enrollee returns home, the Enrollee should fill out a claim form, which is available by contacting the Member Service Department. The Enrollee must submit the claim form along with the receipts to the listed address. The amount submitted must be in American dollars. The Plan may require medical records of the services received. The Enrollee is responsible for providing such medical records. It may be necessary for the Enrollee 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 Enrollee's condition has stabilized.

Ambulance and Transportation Services

This section describes covered services and exclusions for ambulance services. Benefits are provided for local transportation by a vehicle designed, equipped and used only to transport the sick and injured. The vehicle must be operated by trained personnel and licensed as an ambulance to take the Enrollee:

- From the Enrollee'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 is only a benefit when terrain, distance, or the Enrollee's physical condition requires the services of an air ambulance. Anthem, on behalf of the Plan, will determine whether transport by air ambulance is a benefit on a case-by-case basis. If Anthem determines that ground ambulance could have been used, benefits will be limited to ground ambulance benefits. If the Enrollee elects not to receive transport to an Emergency facility after an ambulance has been called, the Enrollee's deductible, coinsurance, and/or copayment will still apply. For emergency Ambulance services rendered by an Out-of-Network Provider you are not required to pay more than you would have been required for services from an In-Network Provider.

For ground or air ambulance when received from a Participating Provider or non-Participating Provider the Enrollee pays the appropriate copayment. Copayments are listed on the *Benefit Summary*.

Ambulance services are subject to Medical Necessity reviews by Us. Emergency Ambulance services do not require Prior Authorization/Precertification and are allowed regardless of whether the Provider is an In-Network or Out-of-Network Provider. For Emergency Ambulance services from by an Out-of-Network Provider you do not need to pay any more than would have been paid for services from an In-Network Provider.

Non-Emergency Ambulance services are subject to Medical Necessity review by Us. Air ambulance services for non-Emergency Hospital to Hospital transfers and all scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Prior Authorization/Precertification. See the section "How To Access Your Services and Obtain Approval of Benefits" under the "Getting Approval for Benefits" for more information. When using an air Ambulance for non-Emergency transportation, We reserve the right to select the air Ambulance Provider.

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 Enrollee could have been transported by automobile, commercial or public transportation without endangering his health or safety.

Outpatient Therapies

This section describes covered services and exclusions for physical therapy, speech therapy, occupational therapy, and cardiac rehabilitation.

From the Member's birth until the Member's sixth (6th) birthday, the level of benefits shall exceed the limit of twenty (20) visits for each therapy if such therapy is indicated in a Member's Treatment Plan for Autism Spectrum Disorders and is determined by Us to be Medically Necessary.

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

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.

Speech therapy benefits for cleft lip and cleft palate treatment 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. Additional speech therapy visits for cleft lip and cleft palate will need to be Pre-authorized by Anthem, on behalf of the Plan, before receiving services.

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.

- Chiropractic/Acupuncture benefits are allowed for services administered by a chiropractor or acupuncturist who acts within the scope of licensing for treatment of an illness or accidental injury. Chiropractic benefits are limited to office visits with manual manipulation of the spine, X-ray of the spine and certain physical modalities and procedures. Acupuncture benefits are limited to the office visit for the treatment of an illness or injury. All chiropractic and acupuncture benefits are limited to a d maximum of 30 visits each per Enrollee's Calendar Year for all care. If an Enrollee visits a chiropractor or acupuncturist more than once in a single day, each such visit will be counted as one visit.

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, stuttering, voice or rhythm disorders.
- Benefits are not covered for dysfunctions that are self-correcting such as language therapy for young children with natural dysfluency of development articulation errors that are self-correcting.
- 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 the Plan.
- The purchase of pools, whirlpools, spas and personal hydrotherapy devices.
- Services related to workers' 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).
- Massage therapy.

Autism Services

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

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

a) Evaluation and assessment services;

b) Behavior training and behavior management and applied behavior analysis, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, for autism spectrum disorders provided by autism services providers;

c) Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies.

d) Prescription Drugs, if covered under this Benefit Booklet;

e) Psychiatric Care;

f) Psychological Care, including family counseling; and

g) Therapeutic Care.

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

Home Health Care/Home IV Therapy

Home Health Care

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

Covered services include the following for up to 60 visits per Enrollee's Calendar Year:

- Professional nursing services performed by a Registered Nurse or a Licensed Practical Nurse.
- 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.
- Medical/social services.
- Medical supplies (including respiratory supplies), durable medical equipment (rental or purchase), oxygen, appliances, prostheses and orthopedic appliances.
- Injectables, IV therapies, infusion medications and/or and other prescription drugs ordinarily not available through a retail pharmacy. These medications must be ordered through the PBM.
- Nutritional counseling by a nutritionist or dietitian.

Home infusion/injection therapy

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

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

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

Hospice Care

This section describes covered services and exclusions for hospice care. 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 Enrollee, or 2) in an inpatient facility.

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

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

Covered services are allowed for routine home hospice care, including any of 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.

Benefits are allowed for the following services:

- 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 Enrollee'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.
- 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 Enrollee.
- 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 *Mental Health and Substance Abuse Care* for those services covered by the Plan.
- 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.
- Pastoral and spiritual counseling.
- Services not directly related to the medical care of the Enrollee, including estate planning, drafting of wills, funeral counseling or arrangement, or other legal services.
-

Nutritional Counseling

Nutritional counseling is a way of looking at your food habits and choices with a food expert who offers diet changes and food ideas right for you. The goal of nutrition counseling is to make the right food choices, and improve the nutritional value and dietary supplements in your diet. Benefits are given for a registered dietitian who is a health worker who knows about diet and foods and who is able to translate that information into the right food choices. Registered dietitians must limit their practice to those methods which conform with applicable laws.

Benefits include:

- Nutritional techniques of evaluation which give measurements and changes;
- Nutritional counseling;
- Nutritional therapy; and
- Help on nutritional supplements.

Coverage is not given for foods, hypnosis, personal training, supplements or vitamins.

Nutritional counseling for the treatment of eating disorders, such as anorexia nervosa and bulimia nervosa is covered under the "Mental Health and Substance Abuse Services" section.

Nutritional counseling provided as part of a preventive visit will be covered under "Preventive Care Services".

Nutritional counseling provided as part of diabetes management will be covered under "Diabetes Management Services". Benefit will be based on place of service.

Human Organ and Tissue Transplant Services

Covered Services are paid as inpatient services, outpatient services, or Doctor home visits and offices services depending on where the services is given and subject to your cost shares.

Covered Transplant Procedure

We cover Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and transfusions as determined by Us when precertified. This includes Medically Necessary acquisition procedures, mobilization, collection and storage. It also includes Medically Necessary myeloablative or reduced intensity preparative chemotherapy, radiation therapy, or a combination of these therapies

Out-of-Network Transplant Provider

Any Provider that has not been chosen as a "Center of Excellence" by Us or has not been selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Transplant Benefit Period

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

Prior Approval and Prior Authorization/Precertification

To maximize your benefits, you should call Our transplant department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation and/or work-up for a transplant. We will help you to maximize your benefits by giving coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, In-Network transplant rules, or exclusions apply. Call the member services phone number on the back of your Health Benefit ID Card and ask for the transplant coordinator. Even if We give a prior approval for the covered transplant procedure, you or your Provider must call Our transplant department for Prior Authorization/Precertification prior to the transplant whether this is performed in an inpatient or outpatient setting.

Prior Authorization/Precertification is required before We will cover benefits for a transplant. Your Doctor must certify, and We must agree, that the transplant is Medically Necessary. Your Doctor should submit a written request for Prior Authorization/Precertification to Us as soon as possible to start this process. Not getting Prior Authorization/Precertification will result in a denial of benefits.

Please note that there are cases where your Provider asks for approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or collection and storage is not an approval for the later transplant. A separate Medical Necessity decision will be needed for the transplant.

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's medical policy.
- Peripheral Stem Cell procedures performed in accordance with Anthem's medical policy.
- Cornea.

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

- 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 an Enrollee is a candidate for any of the covered services specified in this section.
- All human organ and tissue transplants must be Pre-authorized based upon the clinical criteria and guidelines established, adopted or endorsed by Anthem or the Blue Cross and Blue Shield Association in the sole discretion of Anthem. Approval for such covered services will be at the sole discretion of Anthem, on behalf of the Plan.
- All hospital admissions that are not a medical Emergency are subject to Pre-certification/Pre-authorization by Anthem, on behalf of the Plan.
- In the event that the services must be performed based on a medical Emergency, Anthem must be notified within 1-business day after admission.

Enrollees 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 Pre-authorized:

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 the Plan 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 physician's order for evaluation.
- Rehabilitative and restorative physical therapy services.

Surgical covered services

- Surgical covered services in connection with covered human organ and tissue transplants with Pre-certification/Pre-authorization 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 of a 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 an Enrollee 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 Enrollee'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 Enrollee.

Other services

- Transportation costs incurred for travel to and from the site of surgery for covered services. Transportation will be for the Enrollee (the transplant recipient) and one other individual accompanying the Enrollee, or, if the transplant recipient is a minor child, transportation costs for two other individuals accompanying the Enrollee.
- Benefits for transportation and lodging for the transplant recipient and companion(s) limited to a maximum of $10,000 per Transplant Benefit Period, not to exceed $100 total per day for reasonable and necessary lodging and meal expenses. The Enrollee is responsible for monitoring the accumulation of expenses and for submitting supporting documentation of travel expenses. No benefits will be paid until after the transplant services are received. Benefits are not available for travel costs associated with a pre-transplant evaluation if the travel occurs more than one day prior to the actual transplant.
- Transportation of donor organ or tissue.
- Evaluation and surgical removal of the donor organ or tissue and related supplies.

Covered Services related to the donor and/or donated organ or tissue, such as hospital, surgical, medical, storage and transportation costs are subject to a maximum of $25,000 per Transplant Benefit Period.

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 Enrollee'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 Plan Document and Summary Plan Description. Benefits will only be provided for covered services and supplies furnished to the transplant recipient during the period beginning five days before the covered transplant procedure and ending 365 days after the covered transplant procedure is performed.

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 Enrollee 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.
- 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 as 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.
- Non-covered transportation and lodging costs related but not limited to alcohol, meals, child care, mileage, phone calls, laundry.

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 Pre-certification/Pre-authorization guidelines. See *Managed Care Features* heading in ABOUT YOUR HEALTH COVERAGE in this document for information on Pre-certification/Pre-authorization guidelines.

The supplies, equipment and appliances described in this section are a covered benefit only if supplied by a Participating Provider and meet the criteria in Anthem's medical policy.

Medical Supplies

Disposable items which are required for the treatment of an illness or injury on an inpatient or outpatient basis received from a Participating Provider are covered. Benefits are provided for syringes, needles, surgical dressings, splints and other similar items that treat a medical condition.

Durable Medical Equipment

Durable medical equipment including such things as crutches, wheelchairs, breathing equipment and hospital beds, are covered if Medically Necessary and prescribed by a physician. Durable medical equipment generally can withstand repeated use and must serve a medical purpose. The durable medical equipment will be rented or purchased at the Plan'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 the Plan or would have been approved by the Plan. Other situations will be reviewed on a case by case basis. During repair or maintenance of durable medical equipment, the Plan will provide benefits for replacement rental equipment. Durable medical equipment upgrades are covered only if Medically Necessary. Durable medical equipment used as part of an inpatient admission is covered as part of the inpatient hospital admission.

Oxygen and Equipment

Benefits are provided for oxygen and the rental and/or purchase, at the Plan's option, of the equipment needed to administer oxygen (one stationary and one portable unit per Enrollee). Upgrades to the level of equipment provided are covered only if Medically Necessary.

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 Enrollee, and upgrades to orthopedic appliances are covered only when Medically Necessary.

Prosthetic Devices

A prosthetic device replaces all or part of a missing body part or extremity (leg or arm) to increase the Enrollee's ability to function. Benefits are provided for purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices. Upgrades of prosthetic devices are covered only when Medically Necessary.

Other Appliances

Benefits for other appliances include:

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

Medical Supplies and Equipment Exclusions — The following services, supplies or care are not covered:

- Supplies, equipment or appliances, which include comfort, luxury, or convenience items (e.g. wheelchair sidecars, fashion eyeglass frames, or cryocuff unit). Equipment or appliances that the Enrollee requests that include more features than needed for the medical condition are considered luxury, deluxe and convenience items (e.g., motorized equipment, such as electric wheelchairs or electric scooters, when manually operated equipment can be used).
- 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 Enrollees with diabetes), whether functional or otherwise, regardless of the relief they provide.
- Home exercise and therapy equipment.
- Hearing aids and related services and supplies.
- Consumer beds or water beds.
- Repair or replacement needed due to misuse or abuse of any covered medical supply or equipment that is identified in this section.
- Orthopedic shoes not attached to a brace (except for Enrollees with diabetes).

Hearing Aid Services

This section describes covered services for hearing aids for dependent children 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:

- Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid. These evaluations will be provided as part of the *Physician Office Services* section.
- Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment. Initial and replacement hearing aids will be supplied every 5 years, or when alterations to the existing hearing aid cannot adequately meet the dependent child's needs.
- Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid.

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. Dental services are not covered under this Plan Document and Summary Plan Description except under the specific circumstances described below. **This Plan Document and Summary Plan Description provides benefits for medical conditions and should not be considered as the Enrollee's Dental Plan Document and Summary Plan Description**. All dental services and supplies covered under this heading are subject toPre-certification/ Pre-authorization guidelines. See *Managed Care Features* in ABOUT YOUR HEALTH COVERAGE in this document for information on Pre-certification/Pre-authorization guidelines.

Accident-Related Dental Services

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

- Dental services, supplies and appliances are needed because of an accident in which the Enrollee sustained other significant bodily injuries outside the mouth or oral cavity.
- Treatment must be for injuries to your sound natural teeth.
- Treatment must be necessary to restore your teeth to the condition they were in immediately before the accident.

- An injury that results from chewing or biting is not considered an accident, unless the chewing or biting results from a medical or mental condition;

- The first dental services must be performed within 90 days after your accident.
- Related services must be performed within one year after your accident. Services after one year are not covered even if benefits are still in effect.

Benefits for restorations are limited to those services, supplies, and appliances the Plan 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 medically appropriate and Pre-authorized.

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 Enrollee has a non-dental-related physical condition, such as bleeding disorders or heart condition that makes the hospitalization Medically Necessary, and the inpatient admission is Pre-authorized.

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.

Dental Surgery

Medical benefits may be provided from an outpatient facility, physician, dentist or oral surgeon services, (not including charges for the dental services) 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.
- Surgical services related to temporomandibular joint syndrome.
- Surgical removal of impacted wisdom teeth.
- Excision of tumors or cysts from the mouth.

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

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

- Restoring the mouth, teeth, or jaws because of injuries resulting from biting, chewing, or an accident or injury principally damaging the teeth.
- Restorations, supplies, or appliances. Examples of such non-covered items include but are not limited to: cosmetic restorations, cosmetic replacement of serviceable restorations, and materials (such as precious metal) that are not Medically Necessary to stabilize damaged teeth.
- Inpatient or outpatient services required due to the age of the Enrollee, medical condition and/or nature of the dental services except as described above.
- Artificially implanted devices and bone graft for denture wear.
- Medical services related to temporomandibular joint therapy is not covered regardless of medical necessity.
- Administration of anesthesia for dental services, operating and recovery room charges, and 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. . An in-network licensed therapist or home health agency must provide the nutrition services. All services must be Pre-authorized, see *Managed Care Features* in ABOUT YOUR HEALTH COVERAGE in this document for information on Pre-certification/Pre-authorization 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 Enrollees 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 Enrollee's Calendar Year when Pre-authorized by Anthem, on behalf of the Plan.

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

- Enteral feedings (enteral therapy is covered, see above).
- 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 Services

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

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

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

We also cover medicine management for Mental Health and Substance Abuse when given by your medical Doctor, psychiatrist or prescriptive nurse. If the medicine management is given by your medical Doctor, benefits are paid under your medical benefit. If medicine management is given by a psychiatrist or prescriptive nurse, benefits are paid under your mental health benefit. For coverage of Prescription Drugs, see this "Benefits Coverage (What Is Covered)" section.

Inpatient Services. Inpatient care to treat Mental Health and Substance Abuse includes:

Individual psychotherapy;

Group psychotherapy;

Psychological testing;

Family counseling with family Members to help in your diagnosis and care; and

Convulsive therapy including electroshock treatment and convulsive drug therapy.

Outpatient Services. The same services listed above for inpatient are covered on an outpatient basis. What are not covered are room, board and general nursing services. Outpatient services include intensive outpatient treatment.

Partial Hospitalization Services. The same services covered for outpatient services for Mental Health and Substance Abuse are covered when you are in the Hospital for only part of the day. Partial hospitalization treatment is covered only when you receive Medically Necessary care through a day treatment program as decided by the facility.

Prior Authorization/Precertification. Your Doctor should call Our behavioral health administrator to find out Medical Necessity needs, correct treatment level and proper setting. Non-Emergency inpatient services need Prior Authorization/Precertification. See the "How to Access Your Services and Obtain Approval of Benefits" section under "Getting Approval for Benefits" for information.

Prescription Drugs Administered by a Medical Provider

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

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

Important Details About Prescription Drug Coverage

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

Prior Authorization/Precertification

Prior Authorization/Precertification may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization/Precertification should be given. We will give the results of Our decision to both you and your Provider. See the "How to Access Your Services and Obtain Approval of Benefits (Applicable to managed care plans)" section for more information on your Plan's rules.

If Prior Authorization/Precertification is denied you have the right to file a Grievance as outlined in the "Appeals and Complaints" section of this Booklet.

For a list of drugs that need Prior Authorization/Precertification, please call the phone number on your Health Benefit ID Card. The list will be reviewed and updated from time to time. Including a drug or related item on the list does not

guarantee coverage under this Booklet. Your Provider may check with Us to verify drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or generic drugs covered under this Booklet.

Step Therapy

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

Therapeutic Substitution

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

Prescription Drugs

This section describes covered services and exclusions for outpatient pharmacy prescription drugs and medications. Anthem allows inpatient pharmacy benefits for prescription drugs when billed by a hospital or other facility for a covered inpatient stay. Refer to the INPATIENT FACILITY SERVICES heading in this section for information on inpatient care. For special foods and formulas for metabolic and nutritional needs refer to the FOOD AND NUTRITION heading for information. Home intravenous (I.V.) therapy is also a benefit as stated under the heading HOME HEALTH CARE/HOME IV THERAPY.

The outpatient pharmacy benefits available under this certificate are managed by Pharmacy Benefits Manager (PBM). The PBM is the entity with which Anthem has contracted to administer its prescription drug benefits. The PBM offers a nationwide network of Retail Pharmacies, a Mail-Service Pharmacy, and clinical services.

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

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

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

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

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

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

- Prescription Drugs, including self-administered drugs. These are Prescription Drugs that do not need administration or monitoring by a Provider in an office or Facility. Injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit in this section;
- Injectable insulin and syringes used for administration of insulin;
- Oral contraceptive drugs and contraceptive devices. Certain contraceptives are covered under "Preventive Care Services";
- Certain supplies, equipment and appliances (such as those for diabetes). You may contact Us to determine supplies covered through a pharmacy;
- Immunizations required by the "Preventive Care Services" benefit;
- Prescription Drugs that help you stop smoking or reduce your dependence on tobacco products. These Drugs will be covered under the "Preventive Care Services" section;
- FDA approved smoking cessation products, including over the counter nicotine replacement products, when obtained with a Prescription for a Member age 18 and older. These products will be covered under the "Preventive Care Services" section; and
- Compound drugs are covered when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved and require a prescription to dispense, and are not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

Each prescription is subject to a copayment. If the prescription order includes more than one covered drug or supply, a separate copayment is required for each covered drug or supply. The copayment will be the lesser of the member's copayment, , or the Prescription Drug Maximum Allowed Amount. The copayment will not be reduced by any discounts, rebates or other funds received by the PBM from drug manufactures, or similar vendors and/or funds received by Anthem from the PBM. Anthem will make no payment for any covered drug or supply unless Anthem's Prescription Drug Maximum Amount exceeds any applicable copayment for which the member is responsible.

The member is limited a 30-day supply or of a prescription drug. When medically necessary, a one-month vacation override is available if the member is traveling out of the Anthem service area.

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

Tier-1 - means a drug that has the lowest Copayment. This tier has low cost or preferred medications. This tier may include Generic Drugs, Single Source Drugs and Multi-Source Drugs.

Tier-2 - means a drug that has a higher Copayment than those in tier 1. This tier has preferred medications that generally are moderate in cost. This tier may include Generic Drugs, Single Source Drugs and Multi-Source Drugs.

Tier-3 - means a drug that has a higher Copayment than those on tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, or multi-source Brand Drugs.Prescription Drugs will always be dispensed as ordered by your Provider and by applicable state pharmacy regulations. You may request, or your Provider may order, a Brand Name Drug. However, if a Generic Drug is available, you will need to pay the cost difference between the Generic Drug and Brand Name Drug. The difference in cost is in addition to your tier Copayment for the drug. The cost difference between the Generic Drug and Brand Name Drug does not go towards your Out-of-Pocket Annual Maximum. By law, Generic Drugs and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics as a rule saves money, yet provides the same quality. For certain higher cost generic drugs, We keep the right, in Our sole discretion, to make an exception and not require you to pay the difference in cost between the Generic and Brand Name Drug.

Important Note: If We determine that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of In-Network pharmacies may be limited. If this happens, We may require you to select a single In-Network pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single In-Network pharmacy. We will contact you if We determine that use of a single In-Network pharmacy is needed and give you options as to which In-Network pharmacy you may use. If you do not select one of the In-Network pharmacies We offer within 31 days, We will select a single In-Network pharmacy for you. If you disagree with Our decision, you may ask Us to reconsider it by following the procedure outlined in the "Appeals and Complaints" section of this Booklet.

How to Obtain Outpatient Prescription Drug Benefits

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

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

If the member does not present the health benefit ID card at a network pharmacy, the member will have to pay the full cost of the prescription. If the member does pay the full charge, the member should ask the pharmacist for an itemized receipt and submit it to Anthem with a written request for reimbursement. The member will be reimbursed based on the charge for the covered drug, less the network pharmacy discount payable after review and approval of the claim, less the applicable tier 1, tier 2 or tier 3 copayment. Prescription drugs dispensed in excess of a 31-day supply or 100 units of medication are not reimbursable.

Mail Service — Mail service offers a convenient means of obtaining maintenance prescription drugs by mail if the member takes prescription drugs on a regular basis. Covered prescription drugs are ordered directly from the licensed pharmacy mail service that has entered into a reimbursement agreement with Anthem and are sent directly to the member's home. Maintenance prescription drugs are those used on a continuing basis for the treatment of a chronic illness such as heart disease, high blood pressure, arthritis or diabetes. The member must complete the Order and Patient Profile Form, which is available from Member service or on Anthem's website at www.anthem.com or www.ctsi.org. The member will need to complete the patient profile information only once. The member may mail written prescriptions from the physician, or have the physician fax the prescription to the PBM mail service. The member physician may also phone in the prescription to the PBM mail service. The member will need to submit the applicable copayment amounts to the PBM mail service when the member requests a prescription or refill. Class II prescription drugs (e.g., narcotics) will only be dispensed in a 30-day supply. Specialty drugs are eligible for a 90-day mail order supply.

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

- Prescription drugs and supplies received from a non-network pharmacy.
- Non-legend prescription drugs.
- Drugs prescribed for weight control or appetite suppression.
- Medication or preparations used for cosmetic purposes to promote hair growth, prevent hair growth, or medicated cosmetics. These included but are not limited to Rogaine®, Viniqa®, and Tretinoin (sold under such brand names as Retin-A®).

- Any medications used to treat infertility. Special formulas food, or food supplements (unless for metabolic disorders, see *Food and Nutrition* heading for benefits), vitamins, or minerals, except for legend prenatal vitamins.
- 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 this section.
- Therapeutic devices or appliances, including support garments and other nonmedicinal supplies (regardless of intended use).
- Nonprescription and over-the-counter drugs, including herbal or homeopathic preparations, and prescription drugs that have a Clinically Equivalent alternative, even if written as a prescription. Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) except for injectable insulin. The exclusion does not apply to over-the-counter products that must be covered under federal law with a prescription.
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- Prescription drugs, which are dispensed in quantities, which exceed the applicable limits, established by Anthem, at its sole discretion.
- Refills in excess of the quantity prescribed by the provider, or refilled more than one year from the date prescribed.
- Prescription Drugs intended for the treatment of sexual dysfunction or inadequacies, regardless of origin or cause (including drugs for the treatment of erectile dysfunction such as Viagra®).
- Prescription Drugs dispensed for the purpose of international travel.

Private-Duty Nursing Services

The Plan will allow inpatient benefits for private-duty nursing services when the Enrollee's condition ordinarily requires that they are placed in an intensive or coronary care unit, but the hospital does not have such facilities. Outpatient benefits are allowed in the Enrollee's home or other outpatient location.

Private-duty nursing benefits are limited to 60 visits combined inpatient and outpatient payment of $2,000 per Calendar Year. Services over the 60 visit are the Enrollee's responsibility.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Benefit Booklet. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

- Federally funded trials approved or funded by one of the following:
  - The National Institutes of Health.
  - The Centers for Disease Control and Prevention.
  - The Agency for Health Care Research and Quality.
  - The Centers for Medicare & Medicaid Services.
  - Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.

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

  i The Department of Veterans Affairs.

  ii The Department of Defense.

  iii The Department of Energy.

- Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

- Studies or investigations done for drug trials which are exempt from the investigational new drug application.

The Plan may require that you use an In-Network Provider to maximize your benefits.

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

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

1. The Investigational item, device, or service, itself; or

2. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

6. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial

1.

General Exclusions

These general exclusions apply to all benefits described in this Plan Document and Summary Plan Description. This self-funded health benefit plan provides benefits for specific services described in this Plan Document and Summary Plan Description 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 COVERED SERVICES in this document and elsewhere in this Plan Document and Summary Plan Description.

If a service is not covered, then all services performed in conjunction with that service are not covered. Anthem, on behalf of the Plan, is the final authority for determining if services and supplies are Medically Necessary for the purpose of payment.

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

Abortion — This benefit plan does not cover elective abortion. See the heading *Maternity and Newborn Care* in COVERED SERVICES in this document.

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

Artificial conception — All services related to artificial conception are not covered except as provided under the heading *Family Planning* found in COVERED SERVICES in this document.

Auto accident injuries — All services related to auto accidents are not covered except as provided under the heading *Automobile Insurance Provisions* found in ADMINISTRATIVE INFORMATION in this document.

Before Effective Date — This benefit plan does not cover any service received before the Enrollee's Effective Date of benefits.

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

Bariatric Surgery- This benefit plans does not cover any service, supply, or treatment related to Bariatric Surgery.

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

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

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

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

Cosmetic services — This benefit plan does not cover c any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Cosmetic Services are primarily intended to preserve, change or improve your appearance.. No benefits are available for Surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, or chest), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies or previous therapeutic process or pursuant to breast reconstruction following a mastectomy. Reconstructive services are payable only if the original procedure would have been a Covered Service under this Plan.

Court ordered services — This benefit plan does not cover services that are required under court order, parole or probation.

Custodial care — This benefit plan does not cover care primarily for the purpose of assisting the Enrollee 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 COVERED SERVICES 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 benefit plan does not cover hospital services if the Enrollee 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 COVERED SERVICES in this document.

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

Duplicate (double) coverage — This benefit plan does not cover services and supplies already covered by other valid coverage, see the heading *Coordination Of Benefits* in GENERAL PROVISIONS in this document.

Education or training – This benefit plan does not cover charges for or in conjunction with education or training.

Experimental/investigative procedures — A drug, device, medical treatment or procedure which is experimental or investigative, or does not meet accepted standards of medical practice. A drug, device, medical treatment or procedure is experimental or investigative if:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished.
- The drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if Federal Law requires such review or approval.
- Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with a standard means of treatment or diagnosis.
- Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treatment facility or the protocol(s) utilized by other facilities studying substantially the same drug, device, medical treatment or procedure; or the written informed consent document used by the treating facility or by other facilities studying substantially the same drug, device, medical treatment or procedure.

Expenses - This benefit plan does not cover charges for which the Enrollee is not obligated to pay, is not billed or would not have been billed except for the fact that the person was covered under this Plan, unless care is rendered in a Veteran's Administration Hospital for a non-service connected disability.

Family-administered medical treatment – This benefit plan does not cover any treatment or service rendered by a member of the immediate family (Employee, spouse, child, brother, sister or parent of the Employee or spouse).

Fertility treatments – This benefit plan does not cover in vitro procedures, artificial insemination and embryonic implantation procedures.

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

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

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

Hearing — This benefit plan does not cover hearing aids or routine hearing tests except as provided in COVERED SERVICES under *Hearing Aid Services*.

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

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

Immunosuppressant drugs – This benefit plan does not cover 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.

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

Learning deficiency and/or behavioral problem therapies — This benefit plan does not cover services or supplies related to therapies for learning deficiencies and/or behavioral problems except as provided in COVERED SERVICES in this document.

Maintenance therapy — This benefit plan does not cover any treatment that does not significantly enhance or increase the Enrollee's function or productivity, or care provided after the Enrollee has reached his/her maximum medical improvement, except as provided in COVERED SERVICES in this document.

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

Missed appointments — This benefit plan does not cover charges for the Enrollee's failure to keep scheduled appointments. The Enrollee is solely responsible for such charges.

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

Non-covered Providers of service — This benefit plan does not cover services and supplies prescribed or administered by a Provider or other person or facility not specifically listed as covered in this Plan Document and Summary Plan Description. 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.
- Halfway house.
- Massage therapist.
- Nursing home.
- 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 Enrollee upon themselves, by a family member, or by a person who ordinarily resides in the Enrollee's household.
- Acupuncturist.

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

- Adoption expenses.
- Educational classes and supplies not provided by the Enrollee's Provider unless specifically allowed as a benefit under this Plan Document and Summary Plan Description.
- Vocational training services and supplies.
- Mailing and/or shipping and handling expenses.
- Interest expenses and delinquent payment fees.
- Modifications to home, vehicle, or workplace regardless of medical condition or disability.
- Membership fees for spas, health clubs, personal trainers, or other such facilities even if medically recommended, regardless of any therapeutic value.
- Personal convenience items such as air conditioners, humidifiers, or exercise equipment.
- Personal services such as haircuts, shampoos, guest meals, and radio or televisions.
- Voice synthesizers or other communication devices, except as specifically allowed by Anthem's medical policy.

Non-PPO services — Services received from Participating Providers or non-Participating Providers for the following services are not covered:

- Acupuncture.
- Durable medical equipment and supplies.
- Home health care.
- Organ transplants.
- Oxygen.

Nutritional therapy — This benefit plan does not cover food services, meals, formulas and supplements, enteral formulas other than those listed as a Covered Service or resulting from dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.

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

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

Post termination benefits — Benefits are not provided for care received after benefits are terminated except as provided in ELIGIBILITY in this document.

Private room expenses — All services related to a private room are not covered except as provided in COVERED SERVICES in this document.

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

Radiology services — This benefit plan does not cover peripheral bone density testing. This benefit plan does not cover the following except as described by medical policy screening or as provided in this Plan Document and Summary Plan Description - whole body CT scan, routine screening, or more than one routine ultrasound per pregnancy.

Reconstructive surgery — This benefit plan will cover reconstructive surgery only when the surgery is necessary for one or more of the following reasons:

- For repair or alleviation of damage resulting from an accident which occurred while covered under this Plan.
- Because of infection or other disease which occurred while covered under this Plan.
- As a result of a mastectomy procedure.
- Because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect provided the disease or anomaly occurred while covered under this Plan.

Report preparations — This benefit plan does not cover charges for the preparation of medical reports or itemized bills or charges for duplication of medical records from the Provider when requested by the Enrollee.

Reversal of sterilization procedures – This benefit plan does not cover reversals of sterilization procedures.

RU-486 – This benefit plan does not cover charges for or in conjunction with RU-486.

Self-inflicted injuries – This benefit plan does not cover any expenses resulting from self-inflicted injury or attempted self-destruction while sane or insane.

Sexual dysfunction — This benefit plan does not cover services or supplies for the treatment of sexual dysfunction or impotence.

Surrogate pregnancy — This benefit plan does not cover services or supplies provided to a person not covered under this Plan Document and Summary Plan Description in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another women for an infertile couple.

Taxes — This benefit plan does not cover sales, service, or other taxes imposed by law that apply to benefits covered under this Plan Document and Summary Plan Description.

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

Third-party liability (Subrogation) — This benefit plan does not cover services and supplies which may be reimbursed by a third-party, see ADMINISTRATIVE INFORMATION for additional information.

Travel expenses — This benefit plan does not cover travel or lodging expenses for the Enrollee, Enrollee's family or the Physician except as provided under Human Organ And Tissue Transplant Services heading in COVERED SERVICES in this document.

Varicose veins — Sclerotherapy for the treatment of varicose veins in the lower extremities, including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy. Treatment of telangiectatic dermal veins (spider veins) by any method.

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

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

Weight-Loss Programs — This benefit plan does not cover services or supplies related to weight loss unless part of a Disease Management program offered by Anthem, on behalf of the Plan..

Workers' Compensation — This benefit plan does not cover services and supplies for a work-related accident or illness, see ADMINISTRATIVE INFORMATION for additional information. This coverage does not cover charges for or in connection with any accidental bodily injury or sickness for which an individual is entitled (whether or not collectible or whether or not the individual has received a settlement from Workers' Compensation) to receive benefits under a Workers' Compensation Law, Employer's Liability Law or similar law.

Administrative Information

How to File Claims

When a Participating Provider bills Anthem for covered services, Anthem, on behalf of the Plan, will pay the appropriate charges for the benefit directly to the Provider. The Enrollee is responsible for providing the Participating Provider with all information necessary for the Provider to submit a claim. The Enrollee pays the applicable copayment or coinsurance amount to the Provider when the covered service is received. Non-Participating Providers are not required to bill the Plan directly. If a non-Participating Provider does not bill the Plan directly, the Enrollee must file the claim.

How Benefits Are Paid

The Plan shares the cost of your medical expenses with you up to the amount of the Maximum Allowed Amount. For services subject to a Deductible, you must satisfy the Deductible before the Plan begins to pay its share of the balance. If the benefits being accessed do not have a Deductible, then the Plan will pay its share of the cost after any copayment you are required to pay.

The amount you pay may differ by the type of service you receive or by Provider. Refer to the *Benefit Summary* to see what amount you are required to pay for each service. Claims for Covered Services need not be sent to the Plan in the same order that expenses were incurred.

Anthem, on behalf of the Plan, will deny that portion of any charge that exceeds the Maximum Allowed Amount.

Payment of Benefits

Anthem, on behalf of the Plan, will reimbursement directly to non-Participating Providers only when the Enrollee has authorized an assignment of benefits. Anthem requires a copy of the assignment of benefits for their records. If Anthem pays the Enrollee directly, the Enrollee is responsible for paying the non-Participating Provider of services for all charges.

Assignment

This Plan Document and Summary Plan Description is not assignable by the Plan without the written consent of the Plan. The coverage and any benefits under this Plan Document and Summary Plan Description are not assignable by any Member without the written consent of the Plan, except as described in this Plan Document and Summary Plan Description.

Notice of Claim

The Plan is not liable under the Plan Document and Summary Plan Description, unless the Plan receives written notice that Covered Services have been given to you. An expense is considered incurred on the date the service or supply was given.

Note: You have the right to obtain an itemized copy of your billed charges from the Provider who provided services.

Claim Forms

To obtain claim forms, contact the County Health Pool Benefit Administrator/Contact Person or the Member Service department. If Anthem, on behalf of the Plan, does not furnish a claim form to the Enrollee within 15 days of the Enrollee's request, the Enrollee may submit written proof of the claim and will be considered to have complied with the requirements of this Plan Document and Summary Plan Description. The Enrollee 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 Enrollee 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 Enrollee received care. If information is missing on the claim form or is not readable, the form will be returned to the Enrollee. 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.

Separate Claim Forms Required

A separate claim form is required for each non-Participating Provider for which the Enrollee is requesting reimbursement.

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

Inter-Plan Programs

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

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

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

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

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

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

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

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

Non-Participating Healthcare Providers Outside Anthems Service Area

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

Exceptions - In certain situations, Anthem may use other payment bases, such as billed covered charges, the payment Anthem would make if the healthcare services had been obtained within their service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Anthem will pay for services

rendered by Non-participating healthcare Providers. In these situations, you may be liable for the difference between the amount that the Non-Participating healthcare Provider bills and the payment Anthem will make for the Covered Services as set forth in this paragraph.

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

Timely Filing Limits

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

If a claim must be returned to the Enrollee for additional information, the claim must be resubmitted to Anthem, on behalf of the Plan, within 90 days of the date the claim was returned to the Enrollee.

If an Enrollee's coverage under this Plan Document and Summary Plan Description ends, claims for covered expenses incurred during the Enrollee's final Calendar Year must be filed within 60 days after the date of the coverage termination. Failure to file a claim within the 60 days will result in loss of benefits otherwise provided by this medical Plan Document and Summary Plan Description.

Time Benefits Payable

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

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

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

Upon the death of an Enrollee, claims will be payable in accordance with the beneficiary designation. If no such designation is in effect, claims payments will be payable to the Enrollee's estate. If the Provider is a Participating Provider, claims payments will be made to the Provider.

Enrollee's Cooperation

Each Enrollee shall complete and submit to the Plan such consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Workers' Compensation or any other governmental program. Any Enrollee who fails to cooperate will be responsible for any charge for services.

Payment in Error

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

General Provisions

Administration

The Plan, or anyone acting on the Plan's behalf, shall have all the powers necessary or appropriate to enable it to carry out its duties in connection with the operation and administration of this Plan Document and Summary Plan Description. This includes, without limitation, the power to construe the Contract and the Plan Document and Summary Plan Description, to determine all questions arising under this Plan Document and Summary Plan Description, and to make, establish and amend the rules and regulations and procedures with regard to the interpretation and administration of the provisions of this Plan Document and Summary Plan Description. However, these powers shall be exercised in such a manner that has a reasonable relationship to the provisions of the Contract and the Plan Document and Summary Plan Description. A specific requirement, limitation or Exclusion will override more general benefit language.

Amendment

The Plan reserves the right to amend or modify the Plan Document and Summary Plan Description.

Anthem Blue Cross and Blue Shield Note

County Health Pool, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Plan Document and Summary Plan Description constitutes a Contract solely between County Health Pool and Anthem, and that Anthem is the trade name of Rocky Mountain Hospital and Medical Services, Inc. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Authority to Interpret Plan

The County Health Pool Board of Directors, or where Board of Directors' responsibility has been delegated to others, such delegates shall have complete authority to determine the standard of proof required in any case and to apply and interpret the Plan Document and Summary Plan Description. The decisions of the Board of Directors or its delegates shall be final and binding.

Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike or other cause beyond the Plan's control, Anthem, on behalf of the Plan, may be unable to process Enrollee claims on a timely basis. No legal action or lawsuit may be taken against the Plan or Anthem due to a delay caused by any of these events.

Cessation of Operations

In the event of the cessation of operations or dissolution of the Plan, this Plan Document and Summary Plan Description may be terminated immediately by the Plan.

Changes to the Plan Document and Summary Plan Description

For modifications due to applicable Federal Law or regulation, Anthem may amend this Plan Document and Summary Plan Description when authorized by a Plan representative. The Plan will give the Enrollee access to any amendments following the effective date of the amendment.

No agent or employee of Anthem may change this Plan Document and Summary Plan Description. Such changes can be made only through an endorsement authorized and signed by County Health Pool and an officer of Anthem.

Clerical Error

Clerical error of the Plan, in keeping any record pertaining to this coverage will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Contracting Entity

The Employee Participant hereby expressly acknowledges that the Employee Participant understands that the Plan Document and Summary Plan Description constitutes a Contract solely between the Plan 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 Employee Participant further acknowledges and agrees that the Employee Participant has not entered into the Contract based on representations by any person other than a representative of Anthem or the Plan, and that no person, entity or organization other than Anthem will be held accountable or liable to the Employee Participant for any of Anthem's obligations created under the Plan Document and Summary Plan Description. This paragraph does not create any additional obligations whatsoever on Anthem's part other than those obligations created under other provisions of the Plan Document and Summary Plan Description.

Delivery of Documents

Anthem, on behalf of the Plan, will provide an Identification Card for each Enrollee. The Plan Document and Summary Plan Description is available at www.ctsi.org or by calling the Member Service Department.

Disagreement with Recommended Treatment

Each Enrollee enrolls with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate medical care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Disclosure and Release of Medical Information

Ordinarily, Anthem, on behalf of the Plan, cannot release an Enrollee's medical information without the Enrollee's written consent. That information is strictly confidential. Anthem may, however, release an Enrollee's medical information without notice or consent when:

- Requested in connection with utilization summaries or review provided to a third-party, such as a Member, if that third-party funds all or a part of the cost of the Enrollee's claims.
- Peer and utilization review boards when Anthem's medical consultants need such information for review in connection with services an Enrollee receives that may be covered under this Plan Document and Summary Plan Description.
- Anthem receives a judicial or administrative subpoena for such information.
- The information is required for workers' compensation proceedings, auto insurance cases, third-party liability (Subrogation) proceedings, Coordination of Benefits or Medicaid.

Anthem, on behalf of the Plan, cannot release information to an Enrollee that Anthem received from a Provider. If an Enrollee needs to review Provider records, the Enrollee must contact the Provider. Only an Enrollee's Provider can release such information to the Enrollee.

The Enrollee must provide the Plan with whatever information is necessary to determine benefits on the Enrollee's claims and to carry out the provisions of this Plan Document and Summary Plan Description. Anthem, on behalf of the Plan, may obtain information from any insurance company, organization or person when such information is necessary to carry out the provisions of this Plan Document and Summary Plan Description. Such information may be exchanged without consent of or notice to the Enrollee.

The Enrollee agrees to cooperate at all times (including while the Enrollee is hospitalized) by allowing Anthem access to the Enrollee's medical records to investigate claims and verify information provided in the Enrollee's Enrollment Application/Change Form and/or Health Statement. If the Enrollee does not cooperate with the Plan, the Enrollee forfeits the right to benefit payments on claims subject to investigation and acknowledges the Plan's right to cancel the Enrollee's benefits.

To help the Plan determine which services and supplies qualify for benefits, the Enrollee authorizes all Providers of health care services or supplies to provide the Plan with any medically related information pertaining to the Enrollee's treatment.

The Enrollee waives all provisions of law which otherwise restrict or prohibit Providers of health care services or supplies from disclosing or testifying to such information.

Entire Contract

This Plan Document and Summary Plan Description, the Contract, any Riders, Endorsements or Attachments, and the individual applications of the Employee Participant and Dependents, if any, constitute the entire Contract between Anthem and County Health Pool and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to Anthem by County Health Pool and any and all statements made to County Health Pool by Anthem are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Plan Document and Summary Plan Description, shall be used in defense to a claim under this Plan Document and Summary Plan Description.

Form or Content of Plan Document and Summary Plan Description

No agent or employee of Anthem is authorized to change the form or content of this Plan Document and Summary Plan Description. Such changes can be made only through an endorsement authorized and signed by County Health Pool and an officer of Anthem.

Fraudulent Insurance Acts

It is unlawful to knowingly provide false, incomplete or misleading facts or information to the Benefit Administrator/Contact Person for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of benefits and civil damages.

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

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

Anthem, on behalf of the Plan, reserves the right to recoup any benefit payments paid on behalf of an Enrollee if the Enrollee has committed fraud or material misrepresentation in applying for benefits or receiving or filing for benefits.

Identification Card

When you receive care from a Provider, you must show your Identification Card. Possession of an Identification Card confers no right to services or other benefits under this Plan Document and Summary Plan Description. To be entitled to such services or benefits you must be an Enrollee on whose behalf all applicable contributions under this Plan Document and Summary Plan Description have been paid. If you receive services or other benefits to which you are not then entitled under the provisions of this Plan Document and Summary Plan Description you will be responsible for the actual cost of such services or benefits.

Independent Contractors

Anthem has an independent contractor relationship with Anthem's 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 Participating Providers. Anthem has no control over any diagnosis, treatment, care or other service provided to an Enrollee 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 Enrollee while receiving care from any of Anthem's Participating Providers by reason of negligence or otherwise.

Anthem has an independent contractor relationship with County Health Pool. County Health Pool is not Anthem's agent or employee, and Anthem's employees are not employees or agents of the County Health Pool.

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

Modifications

By this Plan Document and Summary Plan Description, the Plan makes coverage available to Employee Participants. However, this Plan Document and Summary Plan Description shall be subject to amendment, modification, and termination in accordance with any of its provisions, without the consent or concurrence of any Enrollee. By electing coverage under the Plan or accepting the Plan's benefits, all Enrollees legally capable of contracting and the legal representatives of all Enrollees incapable of contracting agree to all terms, conditions, and provisions hereof.

Nondiscrimination

No person who is eligible to enroll will be refused enrollment based on medical status, medical care needs, genetic information, previous health information, gender, race, disability or age.

Not Liable for Provider Acts or Omissions

Neither Anthem nor the Plan is responsible for the actual care you receive from any person. This Plan Document and Summary Plan Description does not give anyone any claim, right, or cause of action against the Plan or Anthem based on what a Provider of medical care, services or supplies, does or does not do.

Notice

Any notice given under this Plan Document and Summary Plan Description shall be in writing. The notices shall be sent to: The Plan at its principal place of business; to you at the Employee Participant's address as it appears on the records or in care of County Health Pool; and to Anthem at 700 Broadway, Denver, Colorado 80273.

No Withholding of Benefits for Necessary Care

Anthem does not compensate, reward or incent, financially or otherwise, Anthem's associates for inappropriate restrictions of care. Anthem does not promote or otherwise provide an incentive to employees or physician reviewers for withholding benefit approval for Medically Necessary services to which the Enrollee is entitled. Utilization review and benefit coverage decision making is based on appropriateness of care and service and the applicable terms of this Plan Document and Summary Plan Description.

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

Paragraph Headings

The headings used throughout this Plan Document and Summary Plan Description are for reference only and are not to be used by themselves for interpreting the provisions of the Plan Document and Summary Plan Description.

Physical Examinations and Autopsies

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

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Plan Document and Summary Plan Description with which an Enrollee shall comply.

Relationship of Parties (Member-Enrollee-The Plan)

Neither the Member nor any Enrollee is the agent or representative of Anthem or the Plan.

County Health Plan is a fiduciary agent of the Enrollee. The Plan's notice to the Member will constitute effective notice to the Enrollee. It is the Member's duty to notify the Plan of eligibility data in a timely manner. The Plan is not responsible for payment of Covered Services of Enrollees if the Member fails to provide timely notification of Enrollee enrollments or terminations.

Research Fees

The Plan reserves the right to charge an administrative fee when extensive research is necessary to reconstruct information that has already been provided to the Enrollee in Explanations of Benefits, letters or other documents.

Right of Recovery

Whenever payment has been made in error, the Plan will have the right to recover such payment from you or, if applicable, the Provider. The Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

Sending Notices

All Employee Participant notices are considered sent to and received by the Employee Participant when deposited in the United States mail with postage prepaid and addressed to either:

- The Employee Participant at the latest address in Anthem's eligibility records.
- County Health Pool, if applicable.

Statements and Forms

Employee Participants shall complete and submit to the Member and/or the Plan applications, or other forms or statements the Plan may reasonably request. Employee Participants or applicants for enrollment represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted is true, correct, and complete. Employee Participants and applicants for enrollment understand that all rights to benefits under this Plan Document and Summary Plan Description are subject to the condition that all such information is true, correct and complete. Any material misrepresentation by an Enrollee may result in termination of coverage as provided in the *Termination* section.

The Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Plan Document and Summary Plan Description. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of an Enrollee.

Waiver

No agent or other person, except an authorized representative of the Plan, has authority to waive any conditions or restrictions of this Plan Document and Summary Plan Description, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Automobile Insurance Provisions

Anthem, on behalf of the Plan, will coordinate the benefits of this Plan Document and Summary Plan Description with the benefits of a complying automobile insurance policy.

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

Coordination of Benefits

Enrollee benefits under this Plan Document and Summary Plan Description may be coordinated with the coverage's afforded by complying policy. After any primary coverage's offered by the complying policy are exhausted, Anthem will pay benefits subject to the terms and conditions of this Plan Document and Summary Plan Description. If there is more than one complying policy that offers primary coverage, each will pay its maximum coverage before the Plan is liable for any further payments.

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

The Plan may require proof that the complying policy has paid all primary benefits prior to making any payments to the Enrollee. Alternatively, the Plan may, but is not be required to, pay benefits under this Plan Document and Summary Plan Description and later coordinate with or seek reimbursement under the complying policy. In all cases, upon payment, the Plan is entitled to exercise its rights under this Plan Document and Summary Plan Description and under applicable law against any and all potentially responsible parties or insurers. In that event, Anthem may exercise the rights found in this section under the heading *Third-Party Liability: Subrogation/Reimbursement*.

What Happens If an Enrollee Does Not Have Another Policy – The Plan will not pay benefits for injuries received by the Enrollee and/or the Enrollee's Dependents while the Enrollee is riding in or operating a motor vehicle that the Enrollee owns if the vehicle is not covered by an automobile complying policy as required by law.

The Plan will also pay benefits under the terms of the Plan Document and Summary Plan Description for injuries sustained by an Enrollee who is a non-owner-operator, passenger or pedestrian involved in a motor vehicle accident if that Enrollee's injuries are not covered by a complying policy. In that event, the Plan may exercise the rights found in this section under the heading *Third-Party Liability: Subrogation/Reimbursement*.

Third-Party Liability: Subrogation/Reimbursement

Third-party liability exists when someone other than the Enrollee is legally responsible for the Enrollee's condition or injury. Anthem, on behalf of the Plan, will not pay for any services or supplies under this Plan Document and Summary Plan Description for which a third-party is liable.

The Plan may, however, provide benefits under these conditions:

- When it is established that a third-party liability does not exist.
- When the Enrollee guarantees, **in writing,** to reimburse the Plan for any claims paid by the Plan on the Enrollee's behalf if the third-party later settles with the Enrollee for any amount, or if the Enrollee recovers any damages in court.

The Plan's Rights Under Third-Party Liability

When a third-party is or may be liable for the costs of any covered expenses payable to the Enrollee or on the Enrollee's behalf under this Plan Document and Summary Plan Description, the Plan has Subrogation rights. This means that Anthem, on behalf of the Plan, has the right, either as co-plaintiffs or by direct suit, to enforce the Enrollee's claim against a third-party for the benefits paid to the Enrollee or on the Enrollee's behalf.

Enrollee Obligations Under Third-Party Liability

The Enrollee has an obligation to cooperate in satisfying the Plan's Subrogation interest or to refrain from taking any action that may prejudice the Plan's rights under this Plan Document and Summary Plan Description. If Anthem, on behalf of the Plan, must take legal action to uphold the Plan's rights and if the Plan prevails in that action, the Plan will be entitled to receive, and the Enrollee will be required to pay, the Plan's legal expenses, including attorneys' fees and court costs.

If a third-party is or may be liable for any expenses payable to an Enrollee or on an Enrollee's behalf under this Plan Document and Summary Plan Description, then the following must occur:

- The Enrollee must promptly notify Anthem, on behalf of the Plan, of the Enrollee's claim against the third-party.
- The Enrollee and the Enrollee's attorney must provide for the amount of benefits paid by the Plan in any settlement with the third-party or the third-party's insurance carrier.

- If the Enrollee receives money for the claim by suit, settlement or otherwise, the Enrollee must fully reimburse the Plan for the amount of benefits provided to the Enrollee under this Plan Document and Summary Plan Description. The Enrollee may not exclude recovery for the Plan's health care benefits from any type of damages or settlement recovered by the Enrollee.
- The Enrollee must cooperate in every way necessary to help the Plan enforce the Plan's Subrogation rights.

NOTE: Failure to comply with obligations in this section may result in termination of benefits under this Plan Document and Summary Plan Description.

Coordination of Benefits

Anthem, on behalf of the Plan, coordinates benefits when an Enrollee has coverage with more than one medical and/or dental benefit plan. The provisions of this section concern coordination of all benefits under this Plan Document and Summary Plan Description with benefits under other plans or policies and other Member plans within County Health Pool.

DEFINITION OF WORDS AND TERMS USED IN THIS SECTION

Allowable Expense - Any necessary, reasonable, usual and customary item of expense at least a portion of which is covered under at least one of the plans covering the individual for whom claim is made. When the Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

Claim Determination Period -The portion of a Calendar Year during which an Enrollee would be eligible to receive benefits under this Plan.

Duplicate Coverage - Duplicate Coverage is the term to describe when an Enrollee is covered by this Plan and is also covered by another group or group-type health insurance or health benefits coverage or blanket coverage. The total benefits received by an Enrollee, or on an Enrollee's behalf, from all coverage combined for any claim for covered services will not exceed 100% of the total covered charges.

Plan - any policy or plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by any of the following:

- Any group, franchise, hospital or medical service, prepayment or other coverage arranged through an employer, trustee, union, employee benefit or other association.
- Any coverage under governmental programs, and any coverage required or provided by any statute.
- Any coverage sponsored by, or provided through, a school or other educational institution.
- Automobile (medical payments coverage) insurance.
- Any coverage under Medicare, except that any Enrollee as defined herein shall be considered to be covered for any and all benefits for which such Enrollee is eligible, as provided or considered payable under Medicare, whether or not actually covered thereunder or would have received benefits payable by Medicare had the Enrollee received services in a facility to which Medicare would have paid benefits.

Plan shall be construed separately with respect to each plan, policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such plan, policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

This Plan - Those sections of this Plan Document and Summary Plan Description which provide the benefits subject to these provisions.

Effect on Benefits

These "Coordination of Benefits Provisions" shall apply in determining an Enrollee's benefits under this Plan for any Claim Determination Period if the sum of:

- the benefits that would be payable under this Plan in the absence of these provisions, and
- the benefits that would be payable under all other plans in the absence of similar Coordination of Benefits provisions would exceed the Allowable Expenses incurred by the Enrollee during any Claim Determination Period.

As to any Claim Determination Period for which these provisions apply, the benefits payable for the Allowable Expenses incurred under this Plan shall be reduced to the extent necessary so that the sum of such reduced benefits and all other benefits payable for such Allowable Expenses under all other plans, except as provided in the next paragraph, shall not exceed the total of such Allowable Expenses. Benefits payable under another plan include the benefits that would have been payable had the claim been fully made thereunder.

- If another plan which is involved in the preceding paragraph and which contains a provision coordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
- the rules set forth herein would require this Plan to determine its benefits before such other plan;

then the benefits of such other plan will be ignored for the purposes of determining the benefits under this Plan.

How Anthem, on Behalf of the Plan, Determines Which Coverage is Primary and Which is Secondary

The benefits of a plan which does not contain a Coordination of Benefits provision always shall be determined before the benefits of the plan which does contain a Coordination of Benefits provision.

Duplicate Coverage On Employee Participants

Coverage is primary if the Enrollee claiming benefits is the person in whose name the policy is issued.

The benefits of a coverage which covers a person as an Employee Participant who is neither laid-off nor retired (or as that Employee Participant's Dependent) is primary before those of a coverage which covers that person as a laid-off or retired Employee (or as that Employee's Dependent.

When an Employee Participant (including Dependent family members) has duplicate coverage carried through two or more group plans, the policy that has been in force the longest period of time is primary. The policy that has been in force the shortest period of time is secondary.

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

NOTE: Change in contract administrators is considered continuous coverage. Therefore, the effective date of the coverage for this Plan is the effective date with the original contract administrator.

Duplicate Coverage on Spouses

When an Enrollee's spouse has group coverage through another group plan and is actively working, that coverage is primary for the spouse.

When the coverage carried by the spouse is through retiree or inactive employment, that coverage will be primary over the coverage carried by the Employee Participant.

When the spouse's coverage is through a COBRA policy and This Plan's benefits are active, then the spouse's coverage will be secondary to this Plan's benefits.

If both spouses are employed by the Member and are covered as Employee Participants, these provisions will apply in the same manner as if the spouses were covered under two different plans.

Note: Information on coordinating benefits for Enrollees who hold two insurance policies and Medicare can be found under the heading Enrollees with Medicare and Two Group Insurance Policies.

Duplicate Coverage on Dependent Children (when parents are not separated or divorced)

If both coverage's cover the Enrollee as a Dependent, the benefits of the coverage of the parent whose birthday occurs earlier in the year is primary ("birthday rule") over those of the coverage of the parent whose birthday falls later in that year. However, if both parents have the same birthday (month and day, not year), then the benefits of the coverage that has covered **the parent** and Dependent(s) longest is primary over the coverage which has covered the **other parent** and Dependent(s) for a shorter period of time.

Duplicate Coverage on Dependent Children (when parents are separated or divorced)

The Plan requires a copy of the divorce decree to establish primacy and financial responsibility for medical, dental or other health care expenses for the children of divorced parents.

When the specific terms of a court decree state that one of the parents is responsible for providing health insurance for the child and establishes financial responsibility for medical, dental or other health care expenses for the child, then that parent's insurance policy is primary. The insurance policy of the other parent is the secondary coverage.

When there is no court decree, the insurance policy of the parent with legal custody of the child is primary. When the parent with custody remarries, the custodial parent's coverage remains primary. The stepparent's coverage becomes secondary, and the coverage of the parent without custody pays **after** the stepparent's coverage.

When the rules above under this heading do not establish an order of benefit determination, the benefits of a plan which has covered the individual on whose expense claims is based for the longer period of time shall be determined before the benefits of a plan which has covered such individual for the shorter period of time.

Payment of Benefits to Others-Determining Primacy Between Medicare and the Plan

Active Employee Participants, age 65 or older, are given the option to elect as primary this Plan or Medicare. If the affected Employee Participant elects the benefits of this Plan as primary, the Plan will provide benefits equivalent to the benefits available to individuals under age 65. If an Employee Participant elects Medicare as primary, this Plan will not provide benefits complementary to Medicare. (The Coordination of Benefits provision will not apply.)

When an active Employee Participant, or the Dependent of an Employee Participant, is eligible for Medicare because of total disability, this Plan will provide primary benefits unless the Enrollee has declined to enroll in the Plan. If an Enrollee declines to enroll, this Plan will not provide benefits complementary to Medicare. (The Coordination of Benefits provision will not apply.)

When any Enrollee is eligible for Medicare because of permanent kidney failure (end stage renal disease), this Plan will provide primary benefits for the first 30 months. Thereafter, when such Enrollee incurs the following Eligible Expenses while covered under this Plan:

1. Hospital, surgical or other charges covered under Medicare, and
2. Charges not covered under Medicare.

The Plan's benefits will be payable to the extent that those charges are not covered under Medicare. The Coordination of Benefits provision will apply. (This paragraph does not apply to Enrollees entitled to Medicare solely on the basis of age or disability.)

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

Enrollees with Medicare and Two Group Insurance Policies

If Medicare is secondary to a group coverage (see Medicare primacy rules), the primary coverage covering the Enrollee will pay first, Medicare will pay second, and the coverage covering the enrollee as a retiree or inactive Employee or Dependent will pay third. The order of primacy is not based on the policyholder of the group health insurance.

Enrollee Obligations

Enrollees have an obligation to provide the Plan with current and accurate information regarding the existence of other coverage.

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

Enrollee benefits under this Plan Document and Summary Plan Description will be reduced by the amount that such benefits would duplicate benefits payable under the primary coverage.

The Plan's Rights to Receive and Release Necessary Information

The Plan may release to, or obtain from, any insurance company or other organization or person any information which the Plan may need to carry out the terms of this Plan Document and Summary Plan Description. Enrollees will furnish to the Plan such information as may be necessary to carry out the terms of this Plan Document and Summary Plan Description.

Payment of Benefits to Others

Whenever payments which should have been made under this Plan Document and Summary Plan Description have been made under any other coverage, Anthem, on behalf of the Plan, will have the right to pay to the other coverage any amount Anthem determines to be warranted to satisfy the intent of this provision. Any amount so paid will be considered to be benefits paid under this Plan Document and Summary Plan Description, and with that payment the Plan will fully satisfy the Plan's liability under this provision.

Right of Overpayment Recovery

If Anthem, on behalf of the Plan, has overpaid for covered services under this provision, Anthem, on behalf of the Plan will have the right, by offset or otherwise, to recover the excess amount from the Enrollee or any person or entity to which, or in whose behalf, the payments were made.

Workers' Compensation

To recover benefits under workers' compensation insurance for a work-related illness or injury, the Enrollee must pursue the Enrollee's rights under the Workers' Compensation Act or any of the County Health Pool liability laws that may apply. This includes filing an appeal with the Division of Workers' Compensation. The Plan may pay conditional claims during the appeal process if the Enrollee signs a reimbursement agreement to reimburse the Plan for 100 percent of benefits paid that duplicate benefits paid from another source.

Workers' Compensation

The benefits under this Plan are not designed to duplicate benefits that you are eligible for under Workers'Compensation Law. All money paid or owed by Workers' Compensation for services provided to you shall be paid back by you, or on your behalf, to us if we have made or make payment for the services received. It is understood that coverage under this Plan does not replace or affect any Workers' Compensation coverage requirements.

Services and supplies resulting from work-related illness or injury are not a benefit under this Plan Document and Summary Plan Description, except for those who may opt out of Workers' Compensation coverage, pursuant to state or Federal Law, prior to the illness or injury. This exclusion from benefits applies to expenses resulting from occupational accident(s) or sickness(es) covered under:

- Occupational disease laws
- The Member's liability insurance
- Municipal or Federal Law
- Workers' Compensation Act

The Plan 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 Enrollee fails to file a claim within the filing period allowed by the applicable law.
- The Enrollee obtains care that is not authorized by workers' compensation insurance.
- The Member fails to carry the required Workers' Compensation insurance. In this case, the Member becomes liable for any of the Employee's work-related illness or injury expenses.
- The Enrollee fails to comply with any other provisions of the Workers' Compensation Act.

Complaints, Appeals and Grievance Procedure

This section explains what to do if an Enrollee disagrees with a claim denial in whole or in part, a benefit or network exception request denial or has a quality of care concern. This section includes instructions on initiating a complaint, filing an appeal or filing a grievance with the Plan.

Complaints

If an Enrollee has a complaint about any aspect of the Plan's service or claims processing, the Enrollee should contact the Anthem Member Service Department by telephone or in writing. A Member Service associate will work to clear up any confusion and resolve the Enrollee's concerns. An Enrollee may submit a written complaint to the address listed below. If the Enrollee is not satisfied with the resolution of their concern(s) by the Customer Service associate, the Enrollee may file an appeal as explained under the heading Appeal*s* in this section:

Anthem
Customer Service Department
P.O. Box 17549
Denver, CO 80217-7549

If an Enrollee wants to request a benefit exception, the Enrollee should contact the Member Service Department by telephone or in writing. The Member Service associate will submit the request, obtain a decision and communicate the decision. If the Enrollee is not satisfied with the resolution of the request, the Enrollee may file an appeal as explained under the Appeal*s* heading in this section.

A Provider may request a utilization exception on behalf of the patient by contacting the Anthem Pre-certification/Pre-authorization Department. If the Provider is not satisfied with the resolution of the request, the Provider may file a Utilization Review Appeal as explained under the Appeal*s* heading. The Provider should contact the Pre-certification/Pre-authorization Department by telephone or in writing.

Appeals

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

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

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

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

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

Notice of Adverse Benefit Determination

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

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Administrator's determination is based;
- a description of any additional material or information needed to perfect your claim;

- an explanation of why the additional material or information is needed;
- a description of the plan's review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA (if applicable) within one year of the appeal decision if you submit an appeal and the claim denial is upheld.
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the
- claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

The Administrator's notice will also include a description of the applicable urgent/concurrent review process; the Administrator may notify you or your authorized representative within 24 hours orally and then furnish a written notification.

For Appealing an adverse benefit determination:

You have the right to appeal an adverse benefit determination (claim denial). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim.

The Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Administrator shall offer a 2nd level appeal process for both pre-service and post-service claims. For pre-service claims the 2nd level appeal is voluntary. For post-service claims the 2nd level appeal is mandatory.

Please refer to the section below titled "Requirement to file an Appeal before filing a lawsuit." The 2nd level of appeal for pre-service and post-service claims may include a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

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

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

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal

(e.g. urgent care). You or your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield
ATTN: Appeals
700 Broadway, Mail Stop CO0104-0430
Denver, CO 80273

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

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

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

How Your Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

Second Level Appeals for Pre-Service

If you are dissatisfied with the Plan's first level appeal decision regarding a pre-service claim, a voluntary second level appeal may be available. The Level 2 Appeal must be requested within 60 calendar days after the Enrollee receives Anthem's response to the Level 1 Appeal decision.
Enrollees, or their representative, must send Level 2 Appeals, in writing, to the following address:

County Health Pool Board of Directors
C/O Benefits Manager
800 Grant St., Suite 400
Denver, CO 80203

The Board of Directors will issue a copy of the written decision to the Enrollee and/or the Enrollee's representative, or to the Provider who submits a Level 2 Appeal on the Enrollee's behalf, if any, within 60 workdays of the Board of Directors receipt of the Level 2 Appeal request.

You are allowed to review your Appeals file upon your request.

You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

Second Level Appeals for Post-Service claims
If you are dissatisfied with the Plan's first level appeal decision regarding a post-service claim, you have the right to request a 2nd level appeal. The Level 2 Appeal must be requested within 60 calendar days after the Enrollee receives Anthem's response to the Level 1 Appeal decision.
Enrollees, or their representative, must send Level 2 Appeals, in writing, to the following address:

County Health Pool Board of Directors
C/O Benefits Manager
800 Grant St., Suite 400
Denver, CO 80203

The Board of Directors will issue a copy of the written decision to the Enrollee and/or the Enrollee's representative, or to the Provider who submits a Level 2 Appeal on the Enrollee's behalf, if any, within 60 workdays of the Board of Directors receipt of the Level 2 Appeal request.

You are allowed to review your Appeals file upon your request.

Second level appeals for post-service claims are mandatory and must be completed prior to submitting a request for an independent External Review.

External Review

If the outcome of all mandatory appeals is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

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

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

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal

process. You or your authorized representative may request it orally or in writing. All necessary information, including the Administrator's decision, can be sent between the Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Administrator at the phone number listed on your Health Benefit ID card and provide at least the following information:

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

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

Anthem Blue Cross and Blue Shield
ATTN: Appeals
700 Broadway, Mail Stop CO0104-0430
Denver, CO 80273

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA (if applicable).

Requirement to file an Appeal before filing a lawsuit

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

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

Grievances

A grievance is a quality of care complaint. An Enrollee may send a written grievance to the following address:

Anthem
Quality Management Department
700 Broadway MC0532
Denver, CO 80273

Receipt of the Enrollee's grievance will be acknowledged by Anthem's Quality Management Department and the grievance will be investigated by Anthem's Quality Management Department. Anthem treats each grievance investigation in a strictly confidential manner. Enrollees will not be advised as to the outcome of the grievance investigation.

Legal Action

Before an Enrollee takes legal action on a claim decision, the Enrollee must first follow the process outlined under the heading Appeals in this section and the Enrollee must meet all the requirements of this Plan Document and Summary Plan Description.

No action at law or in equity may be commenced later than two years after the time the Enrollee received the service in question. Performance of this Plan Document and Summary Plan Description shall take place in the City and County of Denver, Colorado. Any action arising at law or in equity under this Plan shall be brought in the courts of the City and County of Denver.

Limitations of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any forum, unless it is commenced no earlier than 60 days after the Plan receives the claim or other requests for benefits and within one year of the Plan's final decision on the claim or any other request for benefits. If the Plan decides an Appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals procedure before filing a lawsuit or other legal action of any kind against the Plan.

Glossary

This section defines words and terms used throughout the Plan Document and Summary Plan Description to help Enrollees understand the content. Enrollees should refer to this section to find out exactly how, for the purposes of this Plan Document and Summary Plan Description, a word or term is used.

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

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

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

Administrative Services Agreement — The agreement between the Plan and Anthem Blue Cross and Blue Shield stating all of the terms and provisions applicable to group benefits. The final interpretation of any specific provision contained in this Plan Document and Summary Plan Description is governed by the Administrative Services Agreement.

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

Alcoholism Treatment Center — an accredited or licensed Hospital, or any other public or private facility or portion thereof providing services especially for the treatment of Substance Dependency which is licensed by the Colorado Department of Human Services for those services.

Alternate Benefits - Benefits for treatment or services that can be achieved through a different or less costly procedure or service with satisfactory results.

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

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

Ambulatory Surgical Center - A specialized facility, coverage of which is regulated by law and licensed in the jurisdiction in which located; or where coverage of such facility is not regulated by law, meets all of the following requirements:

- Is established, equipped and operated primarily for the purpose of performing surgical procedures in accordance with the applicable laws in the jurisdiction in which it is located; and
- Operated under the supervision of a licensed physician as defined herein who devotes full time to such supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one hospital in the area; and
- Requires in all cases other than those requiring only local infiltration anesthetics that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure; and
- Provides at least two operating rooms and at least one post-anesthesia recovery room; is equipped to perform diagnostic X-ray and laboratory examinations; and has trained personnel and necessary equipment available to handle foreseeable emergencies, including but not limited to, a defibrillator, a tracheotomy set and a blood bank or other blood supply; and
- Provides the full-time nursing services of one or more RNs for patient care in the operating rooms and in the post-anesthesia recovery room; and

- Maintains a written agreement with at least one hospital in the Service Area for immediate acceptance of patients who develop complications or require postoperative confinement; and
- Maintains an adequate medical record for each patient, such record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, and laboratory tests and/or X-rays, an operative report, and a discharge summary.

Ancillary Services — Services and supplies (in addition to room services) that hospitals, alcoholism treatment centers and other facilities bill for and regularly make available for the treatment of the Enrollee'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.

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."

Appeal — A process for reconsideration of the Plan's decision regarding an Enrollee's claim, benefit exception, network exception request or utilization review request.

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

Assignment - A decision by the Enrollee to make benefits which ordinarily would be payable to such Enrollee payable directly to the Provider.

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

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

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

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

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

Behavioral Health Administrator - Anthem Behavioral Health. For Pre-certification/Pre-authorization call 1-800-424-4014.

Benefit Administrator/Contact Person – Person at the Member location responsible for managing benefits and enrollment.

Benefit Period — The number of days or units of service, such as two office visits per Enrollee's Calendar Year or 30 days per Calendar Year, for which the Plan will provide benefits during a specified length of time.

Benefit Summary — The document, found in the front of the Plan Document and Summary Plan Description, which identifies the type of benefits, copayment, deductible and coinsurance information.

Billed Charges — A Provider's regular charges for services and supplies, as offered to the public generally and without any adjustment for any applicable Participating Provider 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 coverage's is primary for the coverage of dependent child(ren). Generally, under the birthday rule, the parent whose birthday comes first during the year is considered to have the primary insurance coverage for the child(ren). Any balance may be submitted to the other parent's insurance carrier for additional consideration.

Board of Directors - Refers to the Board of Directors of County Health Pool.

Bylaws - The "County Health Pool Bylaws and Intergovernmental Agreement".

Calendar Year - That period of time beginning on the first day of January and ending on the last day of December in the same Calendar Year.

Care Management — A plan of Medically Necessary and appropriate health care, which is aimed at promoting more effective interventions to meet Enrollee 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 Enrollees, Providers and the Plan to coordinate services deemed Medically Necessary for the Enrollee. A Care Manager is also referred to as a Case Manager.

Certified - In reference to eligible Providers that the institution or individual is Certified to provide such services by the jurisdiction in which services are delivered.

Certified Nurse Midwife - A professional nurse licensed to practice in the jurisdiction where services are rendered, and who is included in an advanced practice registry as a C.N.M. by the appropriate authority of such jurisdiction.

CHP – County Health Pool.

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 Enrollees, can be expected to produce similar therapeutic outcomes for a disease or condition.

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

Coinsurance — A provision under which the Employee Participant and the Plan share costs incurred after the Deductible is met, according to a specific formula. The amount of Coinsurance the Enrollee pays to a Provider is calculated after the determination of the Maximum Allowed Amount, but before the Plan subtracts any discount(s) the Plan may have negotiated with the Provider.

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

Common-Law Spouse - One who is married at common law as interpreted by the courts of the State of Colorado. The requirements for a relationship to gain recognition as a common-law marriage are cohabitation and general reputation as married. Both factors must be present. Mere cohabitation is not sufficient. To establish the presumption of marriage by cohabitation and repute there must be clear, consistent, convincing and positive evidence.

Complaint — An expression of dissatisfaction with the Plan'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 Enrollee's condition. The consulting physician often has specialized skills that are helpful in diagnosing or treating the illness or injury.

Contract - The Contract between County Health Pool and Anthem Blue Cross and Blue Shield. It includes this Plan Document and Summary Plan Description, your Summary of Medical Benefits, the application, any supplemental application or change form, your Identification Card, any Administrative Services Agreement, and any endorsements or riders.

Contract Administrator - Anthem Blue Cross Blue Shield.

Contribution or Costs — Monthly charges that the Enrollee and/or County Health Pool must pay to establish, administer and maintain benefits.

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, an Enrollee may be covered by the Enrollee's own policy, as well as a spouse's policy. Eligible medical expenses are covered first by a person's own policy. Any balance is submitted to the spouse's health insurance carrier for additional consideration.

Copayment — The portion of a claim or medical expense that an Enrollee must pay out of the Enrollee's own pocket to a Provider or a facility for each service. A Copayment is usually a fixed amount that is paid at the time the service is rendered.

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

Cost Sharing — The general term for out-of-pocket expenses, e.g., Copayments and Deductibles, paid by an Enrollee.

Covered Services — Supplies or treatments which are:

- Medically Necessary or otherwise specifically included as a benefit under this Plan Document and Summary Plan Description.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under this Plan Document and Summary Plan Description is in force.

- Not experimental/investigational or otherwise excluded or limited by the Plan Document and Summary Plan Description, or by any amendment or rider thereto.
- Authorized in advance by the Plan if such Pre-certification/Pre-authorization is required by the Plan Document and Summary Plan Description.

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

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 Enrollee. 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.

Member Service - A department of representatives who are dedicated to answering and investigating Enrollee questions and issues related to the Plan.

Days - Calendar days.

Deductible — The dollar amount of Covered Services listed in the Summary of Medical Benefits for which you are responsible before the Plan starts to pay for Covered Services each Calendar Year. Some Covered Services have a maximum benefit of days, visits, or dollar amounts allowed in a Benefit Period. When the Deductible is applied to a Covered Service which has a maximum benefit, the maximum benefit will be reduced by the amount applied toward the Deductible, whether or not the service is paid by this Plan Document and Summary Plan Description.

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

Dependent — A person of the Employee Participant's family who is eligible for coverage under the Plan Document and Summary Plan Description as described in the Eligibility section.

Disabled Dependent — A child of any age who is medically certified as disabled and/or handicapped.

Discharge Planning —The evaluation of an Enrollee's medical needs and arrangement of appropriate care after discharge from a facility.

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 when an Enrollee's coverage begins under this Plan Document and Summary Plan Description. No benefits are provided for services and supplies received before your Effective Date or after your termination date.

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.

Eligibility - A status necessary in order to elect or apply for coverage under the Plan.

Eligible Expenses - The Maximum Allowed Amount made for medical services and supplies that most Physicians would consider to be Medically Necessary for treatment of a particular injury or illness.

Eligible Person - A person who satisfies the Member's eligibility requirements and is entitled to apply to be an Employee Participant or is an eligible Dependent of the Employee Participant. See ELIGIBILITY for more information.

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.

Employee - A person employed by a Member.

Employee Participant — The Employee in whose name the eligibility with the Plan is established.

Enrollee —An Employee Participant or Dependent who has satisfied the Member's eligibility conditions, applied for coverage, been approved by County Health Pool and for whom Contributions have been made. Enrollees are sometimes called "you" and "your".

Enrollee's Calendar Year — The Enrollee's Calendar Year begins on the Employee Participant's Effective Date, and expires on the following December 31; thereafter an Enrollee's Calendar Year commences on each subsequent January 1.

Enrollment Date - The first day of coverage or, if there is a waiting period, the first day of the waiting period.

Entrant - Applicant to this Plan.

Exclusions - Procedures, conditions, injuries, services and expenses incurred for treatment, which will not be paid. See GENERAL EXCLUSIONS in this document.

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, on behalf of the Plan, 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 Covered Services in this Certificate as required by state law), or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function.
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as experimental/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.
- 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 an Enrollee 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 Coverage - Coverage for the Employee Participant and eligible Dependents.

Family Eligibility — An eligibility that covers two or more persons (the Employee Participant and one or more Dependents).

Full-Time Employee - An Employee who meets the requirements as stated in ELIGIBILITY in this document.

General Policies - The guidelines adopted by the Board of Directors concerning the governance and operation of CHP.

Grievance — A written complaint about the quality of care, denial of a benefit or service received from a Provider.

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, occupational therapy and other health-related services provided at home by a Certified home health agency.

Home Health Services — The following services provided by a Certified home health agency under a plan of care to eligible Enrollees 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 Enrollee. Hospice care addresses physical, social, psychological and spiritual needs of the Enrollee and the Enrollee's family.

Hospital — A health institution licensed as a hospital and offering facilities, beds and continuous services 24 hours a day and meets all licensing and certification requirements of local and state regulatory agencies. Hospital also includes "birthing centers" which are either a part of a hospital or are "free standing" providing care by a Certified Nurse Midwife with physician backup or by a physician with service by nurses with specialized training to monitor labor, delivery and after delivery family care.

Identification Card - A card that identifies membership by number, Effective Date of Coverage and may contain information about your coverage. It is important to carry this card with you.

Illness – Non-occupational illness or disease, including pregnancy, which results in a loss covered by the Plan.

Incurred Charge or Expense - The charge for a service or supply is considered incurred on the date furnished. Charges must also be defined as "eligible" if they are to be considered for payment under this Plan Document and Summary Plan Description.

Individual Eligibility — An eligibility covering one person (the Employee Participant).

Injury – Non-occupational bodily damage resulting from an accident occurring while the individual is covered and causing a loss covered by the Plan.

In-Network — A term for Providers or facilities that enter into a PPO network agreement with the Plan. A Provider that is In-Network for one plan may not be In-Network for another. See the section "How To Access Your Services And Obtain Approval Of Benefits" for more information on how to find an In-Network Provider for this Plan.

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

Intensive Care Unit - A section within a hospital operated exclusively for critically ill patients, which provides special supplies and equipment and constant observation and care by registered nurses and other highly trained personnel. Such a unit does not refer to a hospital facility maintained for the purpose of providing normal postoperative recovery, treatment or service.

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.

Late Entrant - An Entrant who submits an enrollment application after the waiting period of the Qualifying Event period expires.

Licensed - In reference to Eligible Providers means that the institution or individual is licensed to provide such services by the jurisdiction in which services are delivered.

Licensed Professional Elected Official- An elected official whose duties include professional services subject to licensure pursuant to title 12, article 25, C.R.S., irrespective of whether such official is licensed or exempt from licensing, and who is authorized by statute under title 30, article 10, C.R.S. to receive additional compensation from the Member for services performed for the Member in addition to duties specified by statute.

Long-Term Acute Care Facility— An institution that provides an array of long term critical care services to Enrollees 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 Enrollees, extensive wound care or post operative surgery wound Enrollees, and low level closed head injury Enrollees. LTAC facilities do not provide care for low intensity patient needs.

Managed Care — System of health care delivery the goal of which is to give Enrollees access to quality, cost effective health care while optimizing utilization and cost of services, and measuring Provider and benefits performance.

Maternity Services — Services required by an Enrollee for the diagnosis and care of a pregnancy (excluding over-the-counter products) and for delivery services. Delivery services include:

- Normal vaginal delivery.
- Caesarean section delivery.
- Spontaneous termination of pregnancy prior to full term.
- Therapeutic termination of pregnancy prior to viability.
- Complications of pregnancy.

Maximum Allowed Amount—The maximum amount that We will allow for Covered Services that you receive. More information can be found in the ABOUT YOUR HEALTH COVERAGE section under Cost Sharing Requirements.

Maximum Medical Improvement — A determination at Anthem's, on behalf of the Plan, sole discretion that no further medical care can reasonably be expected to measurably improve an Enrollee's condition. Maximum medical improvement shall be determined without regard to whether continued care is necessary to prevent deterioration of the condition or is otherwise life sustaining.

Medically Necessary — A confinement, treatment, service or supply which is considered essential to the treatment of the disease or injury and is within the norms and current practices of the medical profession prevailing in the geographical locality where and at the time when the service, supply or treatment is ordered. Determination of "generally accepted practice" is the prerogative of Anthem, on behalf of the Plan, through consultation with appropriate medical or surgical persons.

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

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

Medical 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 - Refers to an entity, or a combination of entities that have collectively agreed to combine through Intergovernmental Agreement to select one entity as primary and all agree to the same plan/benefit package, which has joined County Health Pool through Intergovernmental Agreement or Member Affiliated Entity status and has adopted its Bylaws and General Policies.

Member Affiliated Entity – An entity accepted for plan participation by the County Health Pool Board of Directors over which the Member's Governing Body has at least one of the following controls:

- Approves 50% or more of the governing body of the entity.
- Approves the budget of the entity.
- Provides 50% or more of the funding of the entity.
- Hires, fires or directs the activities of those performing the activities of the entity.

Mental Health Condition —Mental health Conditions that have a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition (e.g., depression secondary to diabetes or primary depression). Mental Health Condition shall not include autism.

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

Nephritis — Infection or inflammation of the kidney.

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

Network Exception - Approval provided by the Plan to receive services from a Participating Provider or non-Participating Provider at the in-network benefit level when there is no Participating Provider of the required specialty available. Approval must be received **prior** to receiving services. Enrollees may be balance billed by the non-Participating Provider authorized through a network exception.

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 the Plan.
- A professional Provider, such as a physician, who has not entered in to an agreement with the Plan.
- Providers who have not contracted or affiliated with the Plan's designated subcontractor(s) for the services they perform under this Plan Document and Summary Plan Description.

Occupational Therapy — The use of educational and rehabilitative techniques to improve an Enrollee's functional ability to live independently. Occupational therapy requires that a properly accredited occupational therapist (OT) or Certified occupational therapy assistant (COTA) perform such therapy.

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

Open-enrollment — During this period, Enrollees may enroll themselves and their Dependents for benefits or change benefits, if this option is available.

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

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

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

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

Out-of-Pocket Annual Maximum— The cost sharing total an Enrollee may be liable for under this Plan Document and Summary Plan Description for most medical expenses during a specified period. The Out-of-Pocket Annual Maximum is designed to protect Enrollees from catastrophic health care expenses. For each Enrollee's 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 Enrollee's Calendar Year. Benefit period maximums, lifetime maximums or maximum dollar limitations under this Plan will still apply, even if the member has satisfied the 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 Enrollee's home.

Oxygen - Is used when there is insufficient oxygen being carried by the blood to the tissues. Oxygen can be administered by mask, nasal tube, tent or in an airtight chamber in which pressure may be increased.

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

Partial Hospitalization – In-hospital treatment for mental and nervous disorders limited to at least three hours but not more than 12 hours in any 24-hour period.

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

Part-Time Employee - An Employee who meets the requirements as stated in ELIGIBILITY in this document.

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 — There is no requirement that a service be rendered by a particular provider.

1. Medical Services

"Physician", in the context of a provider of medical services, means a medical doctor or surgeon (M.D.), a chiropractor (D.C.), or an osteopath (D.O.) who is licensed by the jurisdiction in which he practices.

2. Surgical and Anesthesia Services

"Physician", in the context of a provider of surgical services, means a medical doctor or surgeon (M.D.), a podiatrist (D.P.M.), an osteopath (D.O.), or a dentist or dental surgeon (D.D.S.) who is licensed by the jurisdiction in which he practices.

3. Psychiatrist or Psychological Services

"Physician", in the context of providing psychiatric or psychological services, means a psychiatrist (M.D.), or a psychologist (Ph.D., Ed.D, or Psy,D.) licensed by the jurisdiction in which he practices.

An eligible Provider for such services may include a comprehensive health care service corporation, a hospital, or if within the State of Colorado a community mental health center or other mental health clinic approved by the Colorado Department of Institutions to furnish mental health services.

An eligible Provider for such services may include a therapist licensed by the jurisdiction in which he practices.

4. Diagnostic X-ray or Laboratory Service

"Physician", in the context of prescribing diagnostic X-ray or laboratory services, means a medical doctor (M.D.), a podiatrist (D.P.M.), an osteopath (D.O.), a chiropractor (D.C.), or a dentist or dental surgeon (D.D.S.), who is licensed by the jurisdiction in which he practices.

5. Medical Therapies

Therapies must be prescribed by a physician and performed by a qualified therapist, defined as follows:

a. Occupational Therapist - an individual who is a graduate of an occupational therapy program approved by a nationally recognized accrediting body or who currently holds certification by the American Occupational Therapy Association, Inc.

b. Physical Therapist - an individual who is a graduate of a physical therapy program approved by a nationally recognized accrediting body, who meets any current legal requirements of licensure or registration, and who is currently competent in the field.

c. Respiratory Therapist - an individual who has successfully completed all education, experience and examination requirements and is registered by the National Board for Respiratory Care.

d. Speech Therapist - an individual who has a Certificate of Clinical Competence from the American Speech-Language-Hearing Association.

6. Pharmaceutical Services

"Physician", in the context of pharmaceuticals, means a medical doctor or surgeon (M.D.), an osteopath (D.O.), or a dentist or dental surgeon (D.D.S.) who is licensed by the jurisdiction in which he practices. The dispenser of pharmaceuticals may be either a prescribing physician or a registered pharmacist licensed by the jurisdiction in which he practices.

Plan Administrator – County Health Pool serves as Plan Administrator. The Plan Administrator may contract with a qualified Contract Administrator.

Plan Document and Summary Plan Description — This document, which explains the benefits, limitations, exclusions, terms and conditions of the health benefit plan. In the event of any discrepancy, ambiguity or conflict between the terms of the Plan Document and Summary Plan Description and any other document, the terms of the Plan Document and Summary Plan Description control.

Pre-certification /Pre-authorization —A process in which requests for services are reviewed **prior** to service for approval of benefits, length of stay and appropriate location.

Preferred Provider Organization (PPO) - A panel of licensed Physicians and/or a group of participating health care institutions that have contracted to supply health care services to Plan Enrollees.

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. Anthem will designate brand name prescription drugs as follows:

- As a formulary brand name prescription drug identified on the formulary by Anthem as a prescription drug with a tier-2 copayment as listed on the *Benefit Summary* at the beginning of the SPD.
- As a non-formulary brand name prescription drug **not** identified on the formulary by Anthem as a prescription drug with a Tier-3 copayment as listed on the *Benefit Summary* at the beginning of the SPD.

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 of pharmaceutical products developed in consultation with physicians and pharmacists and approved for their quality and cost effectiveness.

Generic prescription drug — drugs determined by the FDA to be bio-equivalent to brand name drugs and that are not manufactured or marketed under a registered trade name or trademark. A generic drug's active ingredients duplicate those of a brand name drug. Generic drugs must meet the same FDA specifications as brand name drugs for safety, purity and potency and must be dispensed in the same dosage form (tablet, capsule, and cream) as the counterpart brand name drug. On average, generic drugs cost about half as much as the counterpart brand name drug. Generic prescription drugs are identified on the formulary by Anthem as prescription drugs with a tier-1 copayment as listed on the *Benefit Summary* at the beginning of the SPD.

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 as an in-network pharmacy 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.

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

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

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

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

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 the Plan 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 Plan Document and Summary Plan Description. Such services are subject to review by a medical authority appointed by the Plan. Other professional Providers include, among others, Certified nurse midwives, dentists, optometrists and Certified registered nurse anesthetists. Services of such a Provider must be among those covered by this Plan Document and Summary Plan Description and are subject to review by a medical authority appointed by the Plan.

Facility Provider — There are two types of facility Providers, inpatient and outpatient.

Inpatient Facility Provider — A hospital, alcoholism treatment center, hospice facility, skilled nursing facility or other facility which the Plan 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. Hospital also includes "birthing centers" which are either a part of a hospital or are "free standing" providing care by a Certified Nurse Midwife with physician backup or by a physician with service by nurses with specialized training to monitor labor, delivery and after delivery family care.

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, or skilled nursing facility) recognized by the Plan 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 Plan Document and Summary Plan Description and are subject to review by a medical authority appointed by us. Example: ambulatory surgery center.

Qualified Beneficiary — An individual who, on the day before a Qualifying Event, is covered by the Plan as an Employee Participant or an Employee Participant's Dependent.

An Employee Participant can be a Qualified Beneficiary only in connection with a Qualifying Event (termination of coverage due to termination of employment or reduction in hours).

A newborn child, adopted child of a Qualified Beneficiary or a child placed for adoption with a Qualified Beneficiary who was not an Employee Participant will be entitled to the same COBRA coverage period available to the Qualified Beneficiary, however, such child shall not become a Qualified Beneficiary.

A newborn child adopted child or child placed for adoption with a Qualified Beneficiary who was an Employee Participant shall become a Qualified Beneficiary in his/her own right and shall be entitled to benefits as a Qualified Beneficiary.

A Qualified Beneficiary must notify the Member within 31 days of the child's birth, adoption or placement for adoption in order to add the child to the COBRA coverage.

A person who becomes the spouse of a Qualified Beneficiary (regardless of whether the Qualified Beneficiary is the Employee Participant) after a Qualifying Event is not a Qualified Beneficiary.

An Employee Participant, or an Employee Participant's Dependent, who does not elect COBRA Coverage in connection with a Qualifying Event ceases to be a Qualified Beneficiary at the end of the election period.

An individual who elects COBRA Coverage ceases to be a Qualified Beneficiary once the Plan's obligation to provide COBRA Coverage has ended.

Qualifying Event — Any of the following:

- Termination of coverage due to the death of an Employee.
- Termination of coverage due to the voluntary or involuntary termination of employment (other than by reason of gross misconduct) or reduction in hours of an Employee.
- Termination of coverage due to an Employee's change in status, to a classification not covered by the Plan.
- The divorce or legal separation of an Employee from his/her spouse.

- Termination of coverage due to an Employee becoming enrolled in either Part A or Part B of Medicare coverage.
- A Dependent child ceasing to be a Dependent child as defined in ELIGIBILITY in this document.

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 — 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 - Money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical/Dental-Payments", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of the Plan

Referral — Authorization given to an Enrollee to visit another Provider.

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

Same-Sex Domestic Partner — Two individuals, of the same sex, who live together in a long-term relationship of indefinite duration with an exclusive mutual commitment in which the Domestic Partners agree to be jointly responsible for each other's common welfare and to share financial obligations.

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

Second Surgical Opinion — A mechanism used by managed care organizations to reduce unnecessary surgery by encouraging individuals to seek a second opinion prior to specific elective surgeries. In some cases, the health coverage may require a second opinion prior to a specific elective surgery.

Single Coverage - Coverage for the Employee Participant only.

Residential Treatment Center/Facility - a Provider licensed and operated as required by law, which includes:

1. Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24

hour availability.

2. A staff with one or more Doctors available at all times.

3. Residential treatment takes place in a structured Facility-based setting.

4. The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.

5. Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide

multiple levels of care.

6. Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities

(CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

1. Nursing care.

2. Rest care.

3. Convalescent care.

4. Care of the aged.

5. Custodial Care.

6. Educational care.

Service Area - the geographical area where you can get Covered Services from an In-Network Provider.

Skilled Nursing Facility (SNF) - a Facility operated alone or with a Hospital that cares for you after a Hospital stay when

you have a condition that needs more care than you can get at home. It must be licensed by the appropriate agency and

accredited by The Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or otherwise

approved by us. A Skilled Nursing Facility gives the following:

Inpatient care and treatment for people who are recovering from an illness or injury;

1. Care supervised by a Doctor;

2. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, Custodial Care or domiciliary care, treatment of

alcohol or drug dependency; or a place for rest, educational, or similar services.

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

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

Special Enrollment – An enrollment period offered when an Employee Participant and/or Dependents lose coverage under another plan.(Includes loss of Medicaid Coverage and/or State Children's Health Program Coverage (CHIP).

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 — An Employee Participant's legal or common-law spouse.

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

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

Subrogation - The substitution of one person or party in the place of another in connection with a lawful claim, demand, or right.

Substance Dependency — Means alcoholism, drug and other substance abuse. Alcoholism and substance abuse are conditions brought about when an individual uses alcohol, drugs or other substances in such a manner that his or her health is impaired and/or ability to control actions is lost.

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. The Plan, at its sole discretion, determines which surgeries do or do not require a surgical assistant.

The Plan – County Health Pool.

Telemedicine - is used to support health care when you and the Doctor are physically separated. Typically, you

communicate through an interactive mean that is enough to start a link to the Provider who is working at a different location

from you.

Therapeutic Termination of Pregnancy – The termination of a pregnancy induced when necessary to prevent the death of the pregnant woman.

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

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

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

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

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

Utilization Review — A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of, health care services, procedures or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, care management, discharge planning and/or retrospective review. Utilization review also includes reviews to determine coverage. This is based on whether or not a procedure or treatment is considered experimental/investigational in a given circumstance (except if it is a specific Plan Document and Summary Plan Description exclusion), and review of an Enrollee'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.

PLAN INFORMATION

The "Plan Administrator" for the plan is County Health Pool
800 Grant Street, Ste 400
Denver, CO 80203
Telephone (303)861-0507

The "Contract Administrator" **for the Plan (including medical and prescription benefits) is Anthem Blue Cross and Blue Shield**
700 Broadway, Denver, CO 80273
Telephone (303) 226-6911 or 1(866) 698-0087

The "Preferred Provider Organization (PPO)" **for the Plan (including medical and prescription benefits) is Anthem Blue Cross and Blue Shield**
700 Broadway, Denver, CO 80273
Telephone (303) 226-6911 or 1 (866) 698-0087

The Vision Provider **for the Plan is Vision Service Plan**
3333 Quality Dr, Rancho Cordova, CA 95670-7985
Telephone 1 (800) 877-7195

The Dental Provider **for the Plan is Anthem Dental**
P.O. Box 65944 San Antonio, TX 78265
Telephone 1 (855)-769-1467.

The Life Provider **for the Plan is Anthem Life**
1801 Watermark Dr, Ste. 200, Columbus, OH 43215
Telephone 1 (800) 551-7265.

Cancer Screenings

At County Health Pool, We believe cancer screenings provide important preventive care that supports Our mission: to improve the lives of the people We serve and the health of Our communities. We cover cancer screenings as described below.

Pap Tests

All plans provide coverage under the preventive care benefits for a routine annual Pap test and the related office visit. Payment for the routine Pap test is based on the plan's provisions for preventive care. Payment for the related office visit is based on the plan's preventive care provisions.

Mammogram Screenings

All plans provide coverage under the preventive care benefits for routine screening or diagnostic mammogram regardless of age. Payment for the mammogram screening benefit is based on the plan's provisions for preventive care.

Prostate Cancer Screenings

All plans provide coverage under the preventive care benefits for routine prostate cancer screening for men. Payment for the prostate cancer screening is based on the plan's provisions for preventive care.

Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All plans provide coverage for routine colorectal cancer screenings, such as fecal occult blood tests, barium enema, sigmoidoscopies and colonoscopies. Depending on the type of colorectal cancer screening received, payment for the benefit is based on where the services are rendered and if rendered as a screening or medical procedure. Colorectal cancer screenings are covered under preventive care as long as the services provided are for a preventive screening. Payment for preventive colorectal cancer screenings is based on the plan's provisions for preventive care.

The information above is only a summary of the benefits described. The Booklet includes important additional information about limitations, exclusions and covered benefits.

Consolidated Appropriations Act of 2021 Notice

Consolidated Appropriations Act of 2021 (CAA)

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act as well the Provider transparency requirements that are described below.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Billing Act requirements:

- Emergency Services provided by Out-of-Network Providers,
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility, and
- Out-of-Network Air Ambulance Services.

No Surprise Billing Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under your Plan:

- Without the need for Precertification
- Whether the Provider is In-Network or Out-of-Network

If the Emergency Services you received are provided by an Out-of-Network Provider, Covered Services will be processed at the In-Network benefit level.

Note that if you receive Emergency Services from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, Out-of-Network cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the Out-of-Network Provider after you are stabilized, you will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge you any difference between the Maximum Allowable Amount and the Out-of-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided an In-Network Facility

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your claims will be paid at the Out-of-Network benefit level if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge you any difference between the Maximum Allowable Amount and the Out-of-Network Provider's billed charges. This requirement does not apply to Ancillary Services. Ancillary Services are one of the following services: (a) Emergency Services; (b) anesthesiology; (c) pathology; (d) radiology; (e) neonatology; (f) diagnostic services; (g) assistant surgeons; (h) Hospitalists; (i) Intensivists; and (j) any services set out by the U.S. Department of Health & Human Services. In addition, we will not apply this notice and consent process to you if we do not have an In-Network Provider in your area who can perform the services you require.

Out-of-Network Providers satisfy the notice and consent requirement as follows:

- By obtaining your written consent not later than 72 hours prior to the delivery of services, or
- If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

We are required to confirm the list of In-Network Providers in our Provider Directory every 90 days. If you can show that you received inaccurate information from us that a Provider was In-Network on a particular claim, then you will only be liable for In-Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network cost-shares will be calculated based upon the Maximum Allowed Amount. In addition to your In-Network cost-shares, the Out-of-Network Provider can also charge you for the difference between the Maximum Allowed Amount and their billed charges.

How Cost-Shares are Calculated

Your cost shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that we pay In-Network Providers for the geographic area where the Covered Service is provided. Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider or Covered Services from an Out-of-Network Provider at an In-Network Facility and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the "Appeals and Complaints" section of this Benefit Book.

Transparency Requirements

We provide the following information on our website (i.e., www.anthem.com).

- Protections with respect to Surprise Billing Claims by Providers.
- Estimates on what Out-of-Network Providers may charge for a particular service.
- Information on contacting state and federal agencies in case you believe a Provider has violated the No Surprise Billing Act's requirements.
- Upon request, we will provide you with a paper copy of the type of information you request from the above list.
- We, either through our price comparison tool on anthem.com or through Member Services at the phone number on the back of your ID card, will allow you to get:
- Cost sharing information that you would be responsible for, for a service from a specific In-Network Provider.
- A list of all In-Network Providers.
- Cost sharing information on an Out-of-Network Provider's services based on our reasonable estimate based on what we would pay an Out-of-Network Provider for the service.
- In addition, we will provide access through our website to the following information:
- In-Network negotiated rates,
- Historical Out-of-Network rates, and
- Drug pricing information.

The County Health Pool is the Plan Administrator and has an Administrative Services Only Agreement (services by contract) with Anthem to adjudicate claims, provide a network of providers at a discounted rate, 1st level of appeal review and access to various Anthem programs. All other services are provided by CTSI on behalf of the County Health Pool. The County Health Pool also has a dedicated customer service unit at Anthem to assist with claims questions. However, the County Health Pool staff will be available to assist with claims questions if unresolved by Anthem Customer Service.