

Underwritten by Anthem Inc.
Claims Administered by AmeriBen

Student Health Insurance Plan

2019
2020

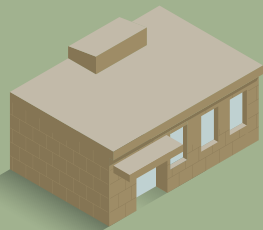
Designed Specifically for The Students of



Information regarding what is covered (benefits) and not covered, Limitations and Exclusions, Notice of Appeal Rights, Definition of Terms, and other medical plan details may be found in the member Certificate as well as the Summary of Benefits and Coverage (and its Supplement). You have a right to access information about your health plan at any time. Please visit <http://www.coloradocollege.edu/offices/studenthealthcenter/insurance/>

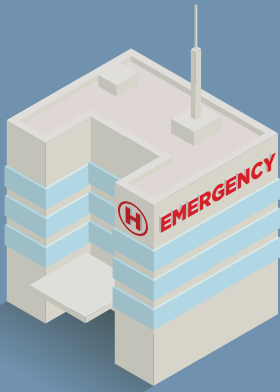
Welcome to Colorado College

Good health is essential for your academic success and the Student Health Center is here to provide high quality health care, counseling, education and prevention services at our campus facility. The program outlined in this brochure provides benefits both within the Student Health Center and when services are provided outside of the Student Health Center. Please take some time to review this brochure and to educate yourself about the benefits that are available to you through the Student Health Insurance Plan.



Student Health Center

The Student Health Center is a student support service that provides a full range of medical, mental health, and health education and prevention services to optimize the health of students and the campus community.



Student Health Insurance Plan

• No policy Deductible, Copay or Coinsurance apply for services received at the Student Health Center.

- Underwritten by Anthem Inc.
- Claims administered by AmeriBen
- \$500 In-Network / \$1,000 Out-of-Network Care deductible (outside the Student Health Center)
- Out of Pocket Maximum - \$6,600 In-Network / \$10,000 Out-of-Network (per individual / per plan year)
- Includes worldwide 24/7 coverage
- No Lifetime Benefit Maximum
- Hospital Room and Board Expense benefits
- Prescription drug benefit with \$15/\$25/\$60 copay for Ingenio Rx network pharmacies.
- Surgical Expense benefits
- Outpatient Expense benefits
- Affordable Care Act compliant health insurance plan
- For additional benefit coverage and more detailed information see pages 1-28

Eligibility For Health Insurance

All degree-seeking registered students or students on an approved study abroad program are automatically enrolled in this insurance plan, unless proof of comparable coverage is furnished.

The student (named insured, as defined in this certificate) must actively attend classes for at least the first 31 days of the semester period for which coverage is purchased. Home study, correspondence, and online courses do not fulfill the eligibility requirements that the student actively attend classes. The carrier maintains its right to investigate eligibility or student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the carrier discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium, less any claims paid.

Students withdrawing after such 31 days will remain covered under the policy for the term purchased and no refund will be allowed.

Waiver Request Process

For additional details on the waiver request process, please visit the Colorado College Student Health Center Insurance page at <https://www.coloradocollege.edu/offices/studenthealthcenter/insurance/> or contact our waiver administrator at 877-974-7462, ext. 315.

Effective And Termination Dates

Policy year effective and termination dates: August 1, 2019 - July 31, 2020

Insured Person: Coverage becomes effective at 12:01 a.m. standard time on the later of:

- The effective date of the Policy;
- The first day of the term of coverage for which premium is paid;
- The day Policy specified date received on which the enrollment form and premium are received by our representative.

Insured Person: Coverage will terminate at 11:59 p.m. standard time on the earliest of:

- The termination date of the Policy;
- The last day of the term of coverage for which premium is paid;
- The date a Insured Person enters full time active military service. We will refund the unearned pro-rata premium to such person upon request.

It is your responsibility to verify your enrollment or waiver status each semester.

The student health insurance policy is a Non-Renewable One Year Term Policy.

Purchasing The Insurance

All eligible students are required to maintain health insurance coverage under a plan that meets Colorado College's insurance requirements or be enrolled in the Colorado College Student Health Insurance Plan (SHIP). To purchase Colorado College SHIP or to review more information about the plan, visit the Colorado College Insurance page at <https://www.coloradocollege.edu/offices/studenthealthcenter/insurance/>.

Semester	Enrollment/Cancellation Deadline
Fall Semester	August 31, 2019
Spring/Summer Semester	January 31, 2020
Summer	June 15, 2020

NOTE: The amounts stated below include certain fees charged by the school and plan administrator for benefits and services associated with offering this health plan.

	Schedule Of Costs		
	Fall	Spring/Summer	Summer Only
Student	\$ 1,170	\$ 1,600	\$ 669

Semester	Coverage Dates For 2019/2020 School Year
	Fall
Spring/Summer	January 1, 2020 - July 31, 2020
Summer	June 1, 2020 - July 31, 2020

The Colorado College Student Health Insurance Plan does not maintain a coverage option for spouse, domestic partner and/or children. Please see the student insurance web page for additional information.

Under the terms of the insurance policy, no enrollments or cancellations may be made after the published Enrollment/Cancellation Deadlines outlined above and therefore, no refunds can be made after this date.

A copy of the Plan document is available upon request

How Do I Find A Preferred Provider?

When you need health care, please access the Student Health Center first for treatment or to obtain a referral to an In-Network Provider. Benefits will be paid at a higher level if you obtain medical treatment or services from an In-Network Provider. You are strongly encouraged to utilize these providers whenever possible as this can reduce your out-of-pocket expenses. Detailed information about In-Network providers is available by visiting www.anthem.com, www.coloradocollege.edu or by calling AmeriBen at (855) 258-6450 or log onto MyAmeriBen.com.

For benefit and claims questions, please call: (855) 258-6450.

Network providers are subject to change. Please contact the provider prior to obtaining medical care/treatment in order to confirm their participation.

Online Services

Please visit the claim administrator's website at www.myameriben.com to obtain your insurance ID cards, claim status information and review Health Benefit Resources. You may also access this information via your smartphone by downloading the MyAmeriBen app on your iOS or Android device.

Other Questions?

Please call the Student Insurance Coordinator at (719)389-6386 or by emailing Kimberly.Taylor@coloradocollege.edu.

Schedule of Medical Expense Benefits

METALLIC LEVEL - GOLD WITH ACTUARIAL VALUE OF 83.49%

In this section you will find an outline of the benefits included in your Plan and a summary of any Deductibles, Coinsurance, and Copayments that you must pay. Also listed are any Benefit Period Maximums or limits that apply. Read the “Limitations/Exclusions (What is Not Covered)” section for details on Excluded Services.

All Covered Services are subject to the conditions, Exclusions, limitations, and terms of this Booklet including any endorsements, amendments, or riders.

To get the highest benefits at the lowest out-of-pocket cost, you must get Covered Services from an In-Network Provider. Benefits for Covered Services are based on the Maximum Allowed Amount, which is the most the Plan will allow for a Covered Service. When you use an Out-of-Network Provider you may have to pay the difference between the Out-of-Network Provider’s billed charge and the Maximum Allowed Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges. This amount can be substantial. Please read the “Claims Procedure (How to File a Claim)” section in the Policy for more details.

Except where the Plan specifically states otherwise, the Deductibles, Coinsurance, and Benefit Period Maximums are calculated based upon the Maximum Allowed Amount, not the Provider’s billed charges.

Essential Health Benefits provided within this Booklet are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, are subject to either a lifetime and/or dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

- Ambulatory patient services,
- Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and Habilitative Services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care.

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any state or federal regulations issued pursuant thereto.

Benefit Period	Policy Year	
Deductible	In-Network	Out-of-Network
Per Member The In-Network and Out-of-Network Deductibles are separate and cannot be combined. When the Deductible applies, you must pay it before benefits begin. See the sections below to find out when the Deductible applies.	\$500	\$1,000

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Student Health Insurance Plan Schedule of Benefits

Coinsurance	In-Network	Out-of-Network
Plan Pays	80%	60%
Member Pays	20%	40%

Reminder: Your Coinsurance will be based on the Maximum Allowed Amount. If you use an Out-of-Network Provider, you may have to pay Coinsurance plus the difference between the Out-of-Network Provider's billed charge and the Maximum Allowed Amount.

Note: The Coinsurance listed above may not apply to all benefits, and some benefits may have a different Coinsurance. Please see the rest of this Schedule for details.

Out-of-Pocket Limit	In-Network	Out-of-Network
The Out-of-Pocket Limit includes all applicable Deductibles, Coinsurance, and Copayments, including Prescription Drugs Coinsurance/Copayments, you pay during a Benefit Period unless otherwise indicated below. It does not include charges over the Maximum Allowed Amount or amounts you pay for non-Covered Services.	\$6,600	\$10,000
The In-Network and Out-of-Network Out-of-Pocket Limits are separate and do not apply toward each other.		

Important Notice About Your Cost Shares

In certain cases, if we pay a Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

The tables below outline the Plan's Covered Services and the cost share(s) you must pay. In many spots you will see the statement, "Benefits are based on the setting in which Covered Services are received." In these cases you should determine where you will receive the service (e.g., in a doctor's office, at an outpatient hospital facility, etc.) and look up that location to find out which cost share will apply. For example, you might get physical therapy in a doctor's office, an outpatient hospital facility, or during an inpatient hospital stay. For services in the office, look up "Office Visits." For services in the outpatient department of a hospital, look up "Outpatient Facility Services." For services during an inpatient stay, look up "Inpatient Services."

Benefits	In-Network	Out-of-Network
Acupuncture/Nerve Pathway Therapy	See "Therapy Services."	
Allergy Services	Benefits are based on the setting in which Covered Services are received.	
Ambulance Services (Air and Water)	20% Coinsurance after Deductible	
<i>For Emergency ambulance services from an Out-of-Network Provider you do not need to pay any more than you would have paid for services from an In-Network Provider.</i>		
Important Note: Air ambulance services for non-Emergency Hospital to Hospital transfers must be approved through Precertification. Please see the section "How to Access Your Services and Obtain Approval of Benefits" in the Policy for details.		
Ambulance Services (Ground)	\$100 Copay per trip, 0% Coinsurance, Deductible Waived	
<i>For Emergency ambulance services from an Out-of-Network Provider you do not need to pay any more than you would have paid for services from an In-Network Provider.</i>		
Important Note: All scheduled ground ambulance services for non-Emergency transfers, except transfers from one acute Facility to another, must be approved through Precertification. Please see the section "How to Access Your Services and Obtain Approval of Benefits" in the Policy for details.		
Autism Services Includes Applied Behavioral Analysis Services	Benefits are based on the setting in which Covered Services are received.	
<i>The limits for physical, occupational, and speech therapy will not apply to children between age 3 and 6 with Autism Spectrum Disorders, if part of a Member's Autism Treatment Plan, and determined Medically Necessary by Us.</i>		

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Student Health Insurance Plan Schedule of Benefits

Benefits	In-Network	Out-of-Network
Behavioral Health Services	See "Mental Health, Alcohol and Substance Abuse Services."	
Cardiac Rehabilitation	See "Therapy Services."	
Chemotherapy	See "Therapy Services."	
Chiropractic Care	See "Therapy Services."	
Clinical Trials	Benefits are based on the setting in which Covered Services are received.	
Dental Services For Members Through Age 18		
• Diagnostic and Preventive Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
• Basic Restorative Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
• Endodontic Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
• Periodontal Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
• Oral Surgery Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
• Major Restorative Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
• Prosthodontic Services	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
• Dentally Necessary Orthodontic Care	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Dental Injuries Benefits paid on Injury to Sound, Natural Teeth only.	20% Coinsurance after Deductible	
Diabetes Equipment, Education, and Supplies Screenings for gestational diabetes are covered under "Preventive Care."	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Services	Benefits are based on the setting in which Covered Services are received.	
Dialysis	See "Therapy Services."	
Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies (Received from a Supplier)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Prosthetics	0% Coinsurance after Deductible	40% Coinsurance after Deductible
<i>The cost-shares listed above only apply when you get the equipment or supplies from a third-party supplier. If you receive the equipment or supplies as part of an office or outpatient visit, or during a Hospital stay, benefits will be based on the setting in which the covered equipment or supplies are received.</i>		
Replacement hearing aids will be supplied every 5 years. New hearing aid will be a covered service when alterations to your existing hearing aid cannot adequately meet your needs or be repaired.	One hearing aid every 5 years In- and Out-of-Network combined	

Student Health Insurance Plan Schedule of Benefits

Benefits	In-Network	Out-of-Network
Emergency Room Services		
<ul style="list-style-type: none"> Emergency Room Facility Charge Emergency Room Doctor Charge Other Facility Charges (including diagnostic x-ray and lab services, medical supplies) Advanced Diagnostic Imaging (including MRIs, CAT scans) 	\$50 Copay per visit, 0% Coinsurance, Deductible Waived Copayment waived if admitted	
Habilitative Services	Benefits are based on the setting in which Covered Services are received. See "Inpatient Services" and "Therapy Services"	
Home Care		
<ul style="list-style-type: none"> Home Care Visits 	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<ul style="list-style-type: none"> Skilled Nursing Facility 	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<ul style="list-style-type: none"> Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia) 	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Services (Precertification Required)		
Facility Room & Board Charge:		
<ul style="list-style-type: none"> Hospital / Acute Care Facility: 	\$400 Copay per Hospital Confinement, 20% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
<ul style="list-style-type: none"> Skilled Nursing Facility: 	\$200 Copay per Hospital Confinement, 20% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
<ul style="list-style-type: none"> Other Facility Services / Supplies (including diagnostic lab/x-ray, medical supplies, therapies, anesthesia): 	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Doctor Services for:		
<ul style="list-style-type: none"> General Medical Care / Evaluation and Management (E&M): 	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<ul style="list-style-type: none"> Surgery: 	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<ul style="list-style-type: none"> Bariatric Surgery: 	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<ul style="list-style-type: none"> Maternity Visits (Global fee for the ObGyn's prenatal, postnatal, and delivery services) 	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<ul style="list-style-type: none"> Inpatient Services (Delivery) 	See "Inpatient Services."	

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Student Health Insurance Plan Schedule of Benefits

Benefits	In-Network	Out-of-Network
Newborn / Maternity Stays: If the newborn needs services other than routine nursery care or stays in the Hospital after the mother is discharged (sent home), benefits for the newborn will be treated as a separate admission.		
<ul style="list-style-type: none"> • Infertility <i>Cover based on Anthem medical policy. Treatment to include artificial insemination, including related prescription drugs, that satisfies Anthem's medical policy. Donor eggs, donor semen, or services related to their procurement or storage are not covered.</i> 	Benefits are based on the setting in which Covered Services are received.	Benefits are based on the setting in which Covered Services are received.
Massage Therapy	See "Therapy Services."	
Mental Health, Biologically Based Mental Illness, Alcohol and Substance Abuse Services		
<ul style="list-style-type: none"> • Inpatient Facility Services 	\$400 Copay per Hospital Confinement, 20% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
<ul style="list-style-type: none"> • Residential Treatment Center Services 	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<ul style="list-style-type: none"> • Inpatient Doctor Services 	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health, Biologically Based Mental Illness, Alcohol and Substance Abuse Services (Continued)		
<ul style="list-style-type: none"> • Outpatient Facility Services 	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<ul style="list-style-type: none"> • Outpatient Doctor Services 	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<ul style="list-style-type: none"> • Partial Hospitalization Program / Intensive Outpatient Services 	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<ul style="list-style-type: none"> • Office Visits (Including Online Visits and Intensive In-Home Behavioral Health Programs) 	\$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
<i>Mental Health, Biologically Based Mental Illness, Alcohol and Substance Abuse Services will be covered as required by state and federal law. Please see "Mental Health Parity and Addiction Equity Act" in the "Additional Federal Notices" section of the Policy for details.</i>		
Occupational Therapy	See "Therapy Services."	
Office Visits		
<ul style="list-style-type: none"> • Primary Care Physician / Provider (PCP) 	\$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
<ul style="list-style-type: none"> • Specialty Care Physician / Provider (SCP) 	\$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
<ul style="list-style-type: none"> • Retail Health Clinic Visit 	\$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible

Student Health Insurance Plan Schedule of Benefits

Benefits	In-Network	Out-of-Network
Office Visits (Continued)		
• Counseling - Includes Family Planning and Nutritional Counseling (Other than Eating Disorders)	\$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
• Nutritional Counseling for Eating Disorders	\$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
• Allergy Testing	0% Coinsurance after Deductible	40% Coinsurance after Deductible
• Allergy Shots / Injections (other than allergy serum)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
• Preferred Diagnostic Labs (i.e., reference labs)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Lab (non-preventive)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic X-ray (non-preventive)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Tests (non-preventive; including hearing and EKG)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
• Office Surgery	0% Coinsurance after Deductible	40% Coinsurance after Deductible
• Therapy Services:		
Chiropractic Care / Manipulation Therapy (regardless of the Provider type rendering the service)	\$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Acupuncture/Nerve Pathway Therapy & Massage Therapy	Not covered except for in lieu of anesthesia	Not covered except for in lieu of anesthesia
Physical, Speech, & Occupational Therapy	\$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Dialysis / Hemodialysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Radiation / Chemotherapy / Non-Preventive Infusion & Injection	0% Coinsurance after Deductible	40% Coinsurance after Deductible
Cardiac Rehabilitation & Pulmonary Therapy	\$25 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Prescription Drugs Administered in the Office (includes allergy serum)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Orthotics	See "Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies."	

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Benefits	In-Network	Out-of-Network
Outpatient Facility Services		
• Facility Surgery Charge	\$300 Copay per date of service, 20% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
• Other Facility Surgery Charges (including diagnostic x-ray and lab services, medical supplies)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Doctor Surgery Charges	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Doctor Charges (including Anesthesiologist, Pathologist, Radiologist, Surgical Assistant)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Other Facility Charges (for procedure rooms or other ancillary services)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Lab	0% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic X-ray	0% Coinsurance after Deductible	40% Coinsurance after Deductible
• Diagnostic Tests: Hearing, EKG, etc. (Non-Preventive)	0% Coinsurance after Deductible	40% Coinsurance after Deductible
• Advanced Diagnostic Imaging (including MRIs, CAT scans)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Therapy:		
Chiropractic Care / Manipulation Therapy (regardless of the Provider type rendering the service)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical, Speech, & Occupational	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Radiation / Chemotherapy / Non-Preventive Infusion & Injection	0% Coinsurance after Deductible.	40% Coinsurance after Deductible
Dialysis / Hemodialysis	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Cardiac Rehabilitation & Pulmonary Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Prescription Drugs Administered in an Outpatient Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical Therapy	See "Therapy Services."	
Preventive Care <i>Preventive care from an Out-of-Network Provider is not subject to the Maximum Allowed Amount.</i>	No Copayment, Deductible, or Coinsurance	40% Coinsurance after Deductible
Prosthetics	See "Prosthetics" under "Durable Medical Equipment (DME), Medical Devices, Medical and Surgical Supplies."	
Pulmonary Therapy	See "Therapy Services."	

Student Health Insurance Plan Schedule of Benefits

Benefits	In-Network	Out-of-Network
Radiation Therapy	See "Therapy Services."	
Rehabilitation Services	Benefits are based on the setting in which Covered Services are received. See "Inpatient Services" for details on Benefit Maximums.	
Respiratory Therapy	See "Therapy Services."	
Skilled Nursing Facility	\$200 Copay per Hospital Confinement, 20% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
Speech Therapy	See "Therapy Services."	
Surgery	Benefits are based on the setting in which Covered Services are received.	
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Therapy Services	Benefits are based on the setting in which Covered Services are received.	
• Physical Therapy (Rehabilitative)	Unlimited	
• Physical Therapy (Habilitative)	Unlimited	
• Occupational Therapy (Rehabilitative)	Unlimited	
• Occupational Therapy (Habilitative)	Unlimited	
• Speech Therapy (Rehabilitative)	Unlimited	
• Speech Therapy (Habilitative)	Unlimited Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from Injury, trauma, stroke, surgery, cancer, or vocal nodules	
• Chiropractic Care / Manipulation Therapy (regardless of the Provider type rendering the service)	Unlimited	
• Acupuncture/Nerve Pathway Therapy & Massage Therapy	Acupuncture: Exclusion, except when used in Lieu of Anesthesia	
• Cardiac Rehabilitation	Unlimited	
Note: The limits for physical, occupational, and speech therapy will not apply if you get that care as part of the Hospice benefit.		
Transgender Services Precertification required	Benefits are based on the setting in which Covered Services are received.	
Transplant Services Precertification required	See "Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services."	

Student Health Insurance Plan Schedule of Benefits

Benefits	In-Network	Out-of-Network
Urgent Care Services (Office Visits)		
<ul style="list-style-type: none"> Urgent Care Office Visit Charge Allergy Shots / Injections (other than allergy serum) Preferred Diagnostic Labs (i.e., reference labs) Other Charges (e.g., diagnostic x-ray and lab services, medical supplies) Advanced Diagnostic Imaging (including MRIs, CAT scans) Office Surgery Prescription Drugs Administered in the Office (includes allergy serum) 	\$35 Copay per visit, 0% Coinsurance, Deductible Waived	40% Coinsurance after Deductible
<i>If you get urgent care at a Hospital or other outpatient Facility, please refer to "Outpatient Facility Services" for details on what you will pay.</i>		
Vision Services For Members Through Age 18		
Note: Benefits for Vision Services are not subject to any Deductible stated in this Plan. Any amount the Member pays in Copayment for Vision Services does not apply to any Deductible stated in this Plan.		
<ul style="list-style-type: none"> Routine Eye Exam <i>Limited to one exam per school year per Member.</i> 	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
<ul style="list-style-type: none"> Standard Plastic Lenses 		
Single Vision	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Bifocal	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Trifocal	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Standard Progressive	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Additional lens options: Covered lenses include factory scratch coating, UV coating, standard polycarbonate, and standard photochromic.	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
<ul style="list-style-type: none"> Frames 	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
<ul style="list-style-type: none"> Contact Lenses <i>Elective or non-elective contact lenses from the Anthem Formulary are covered every Benefit Period per Member.</i> 		
Elective Contact Lenses (Conventional or Disposable)	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived
Non-Elective Contact Lenses	0% Coinsurance, Deductible Waived	0% Coinsurance, Deductible Waived

Student Health Insurance Plan Schedule of Benefits

Benefits		In-Network	Out-of-Network
Vision Services (All Members / All Ages) (For medical and surgical treatment of injuries and/or diseases of the eye) Certain vision screenings required by Federal law are covered under the "Preventive Care" benefit.		Benefits are based on the setting in which Covered Services are received.	
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services To best understand your benefits, you may call our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. We suggest you do this before you have an evaluation and/or work-up for a transplant, so that we can assist you in maximizing your benefits. To learn more or to find out which Hospitals are In-Network Transplant Providers, you may contact the Member Services telephone number on the back of Your Identification Card and ask for the transplant coordinator. In addition, you or your Provider must call our Transplant Department for Precertification prior to the transplant, whether this is performed in an Inpatient or Outpatient setting.			
The requirements described below do not apply to the following: <ul style="list-style-type: none"> • Cornea and kidney transplants, which are covered as any other surgery; and • Any Covered Services related to a Covered Transplant Procedure, that you get before or after the Transplant Benefit Period. Please note that the initial evaluation, any added tests to determine your eligibility as a candidate for a transplant by your Provider, and the collection and storage of bone marrow/stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service. 			
Benefits for Covered Services that are not part of the Human Organ and Tissue Transplant benefit will be based on the setting in which Covered Services are received.			
Transplant Benefit Period	In-Network Transplant Provider	Out-of-Network Transplant Provider	
	Starts one day before 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 information for services received at or coordinated by an In-Network Transplant Provider Facility.	Starts one day before a Covered Transplant Procedure and continues to the date of discharge at an Out-of-Network Transplant Provider Facility.	
Covered Transplant Procedure during the Transplant Benefit Period	In-Network Transplant Provider Facility	Out-of-Network Transplant Provider Facility	
• Precertification required	During the Transplant Benefit Period, 20% Coinsurance after Deductible Before and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	During the Transplant Benefit Period, 40% Coinsurance after Deductible. During the Transplant Benefit Period, Covered Transplant Procedure charges at an Out-of-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit. If the Provider is also an In-Network Provider for this Plan (for services other than Covered Transplant Procedures), then you will not have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. If the Provider is an Out-of-Network Provider for this Plan, you will have to pay for Covered Transplant Procedure charges over the Maximum Allowed Amount. Prior to and after the Transplant Benefit Period, Covered Services will be covered as Inpatient Services, Outpatient Services, Home Visits, or Office Visits depending where the service is performed.	

Information regarding what is covered (benefits) and not covered, Limitations and Exclusions, Notice of Appeal Rights, Definition of Terms, and other medical plan details may be found in the member Certificate as well as the Summary of Benefits and Coverage (and its Supplement). You have a right to access information about your health plan at any time. Please visit <https://www.coloradocollege.edu/offices/studenthealthcenter/insurance/>

Student Health Insurance Plan Schedule of Benefits

Benefits	In-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers	Out-of-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers
Covered Transplant Procedure during the Transplant Benefit Period	20% Coinsurance after Deductible	40% Coinsurance after Deductible These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	0 % Coinsurance	0 % Coinsurance
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services		
• Transportation and Lodging Limit	Covered, as approved by us, up to \$10,000 per transplant. In- and Out-of-Network combined	
Human Organ and Tissue Transplant (Bone Marrow / Stem Cell) Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Donor Search Limit	Covered, as approved by us, up to \$30,000 per transplant. In- and Out-of-Network combined	
Live Donor Health Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
• Donor Health Service Limit	Medically Necessary charges for getting an organ from a live donor are covered up to our Maximum Allowed Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	

Prescription Drug Retail Pharmacy and Home Delivery (Mail Order) Benefits	In-Network	Out-of-Network
At least one product in all 18 approved methods of contraception is covered under this policy without cost sharing as required by federal and state law. Otherwise, each Prescription Drug will be subject to a cost share (e.g., Copayment/Coinsurance) as described below. If your Prescription Order includes more than one Prescription Drug, a separate cost share will apply to each covered Drug. You will be required to pay the lesser of your scheduled cost share or the Maximum Allowed Amount.		
Prescription Drug Co-Payment (0% Coinsurance, Deductible Waived)		\$15 copay for generic \$25 copay for brand name \$60 copay for non-preferred brand. Mail order covered for 90 days at 2.5 times the Copay.
Day Supply Limitations – Prescription Drugs will be subject to various day supply and quantity limits. Certain Prescription Drugs may have a lower day-supply limit than the amount shown below due to other Plan requirements such as prior authorization, quantity limits, and/or age limits and utilization guidelines.		
Retail Pharmacy (In-Network and Out-of-Network)		30 days
Home Delivery (Mail Order) Pharmacy		90 days
Specialty Pharmacy		30 days* <i>*See additional information in the “Specialty Drug Copayments / Coinsurance” section below.</i>

Specialty Drug Copayments / Coinsurance:

Please note that certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. Please see “Specialty Pharmacy” in the section “Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy” for further details. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayments/Coinsurance you pay for a 30-day supply at a Retail Pharmacy.

Note: Prescription Drugs will always be dispensed as ordered by your Doctor. You may ask for, the Brand Name Drug. However, if a Generic Drug is available, you will have to pay the difference in the cost between the Generic and Brand Name Drug. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. Using generics generally saves money, yet gives the same quality. For certain higher cost generic drugs, we reserve 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.

Note: No Copayment, Deductible, or Coinsurance applies to certain diabetic and asthmatic supplies when you get them from an In-Network Pharmacy. These supplies are covered as Medical Supplies and Durable Medical Equipment if you get them from an Out-of-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment / Coinsurance.

Student Health Insurance Plan Schedule of Benefits

Federal Patient Protection and Affordable Care Act Notices

Choice of Primary Care Physician / Provider

We generally allow the designation of a Primary Care Physician / Provider (PCP). You have the right to designate any PCP who participates in our network and who is available to accept you or any of your enrolled family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Access to Obstetrical and Gynecological (ObGyn) Care

You do not need referral or authorization from us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of your Identification Card or refer to our website, www.anthem.com.

Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, plans subject to the Act which offer mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the plan. Also, the plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits. Medical Necessity criteria are available upon request.



Eligibility

All Participants enrolled in an Anthem Insurance Solution Health Program when over 100 miles from your home in the US or outside your home country.

How can Global Core help?

The Blue Cross Blue Shield Global Core Program provides you with access to preferred doctors and hospitals in nearly 190 countries and territories around the world. You can also find other valuable resources to help you stay safe and healthy around the world.

In the event of a medical emergency...

In the event of an emergency, you should go immediately to the nearest physician or hospital without delay and then contact Global Core. If you are not sure where the nearest medical facility is, you can contact Global Core for a referral or use local emergency response in a true emergency. Global Core will take the appropriate action to assist and monitor the medical care until the situation is resolved. In the event the medical facility you are in is not adequate to treat you, GeoBlue will pay and arrange for your medically supervised evacuation to the closest adequate facility.

After being treated at a medical facility, if it is deemed medically necessary for you to continue treatment or recover at home, GeoBlue will make arrangements to return you to your home with a qualified medical attendant.

In the event of a political or natural disaster event which threatens your safety...

If you feel unsafe or experience a direct threat to your safety, contact GeoBlue immediately, you will be connected to a security professional to provide immediate advice and then assess your situation to determine appropriate next steps. Political and natural disaster evacuation coverage is effective only when traveling outside your home country.

The service providers shown MUST always arrange and pay for all services; expenses are not reimbursable on a pay and claim basis.

SERVICES AND BENEFITS

Medical Assistance (by Global Core)	Limits are per Member, per Event
Medical , Dental and Pharmacy Referrals	24/7 access to assistance
Medical Monitoring	24/7 access to assistance
24 Hour Nurse Help Line	24/7 access to assistance
Prescription Assistance	24/7 access to assistance
Guarantee or Advance of Medical Expenses	24/7 access to assistance
Travel Assistance (by GeoBlue)	Limits are per Member, per Event
Emergency Medical Evacuation	\$250,000, from inadequate to adequate facility
Medical Repatriation	Combined Service Limit with Evacuation, when medically necessary
Return of Remains	\$50,000, in the event of death
Pre-Trip Information	24/7 access to assistance
24/7 Emergency Travel Arrangements	24/7 access to assistance
Translator and Interpreter Assistance	24/7 access to assistance
Emergency Travel Funds Assistance	24/7 access to assistance
Legal Consultation and Referral	24/7 access to assistance
Lost/Stolen Document Replacement	24/7 access to assistance
Emergency Message Forwarding	24/7 access to assistance
Lost Luggage Assistance	24/7 access to assistance
Security Assistance (by GeoBlue)	Limits are per Member, per Event
Political or Natural Disaster Evacuation and Return Home	\$100,000 for evacuation to Safe Haven, includes lodging in Safe Haven and return to home or alternate work/study location
Additional Benefits (by GeoBlue)	Limits are per Member, per Event
Accidental Death and Dismemberment	\$10,000 maximum benefit

For worldwide emergency medical, legal and travel assistance information and referral services 24 hours a day, 365 days a year call:

Global Core Toll Free.....800-810-BLUE(2583)

GeoBlue Worldwide Collect....833-511-4763

Global Core Worldwide Collect..... 804-673-1177

The services listed on this page are being provided by two separate companies. Global Core is providing medical/travel assistance and GeoBlue is providing Political and Natural Disaster evacuation services. This is only a summary of the terms, conditions, exclusions and limitations. Additional details may be obtained by contacting 877-974-7462.

In this section you will find a review of items that are not covered by your Plan. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by your Plan.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by your Plan.

- 1) **Acts of War, Disasters, or Nuclear Accidents** - In the event of a major disaster, epidemic, war, or other event beyond our control, we will make a good faith effort to give you Covered Services. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of war, service in the armed forces, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience.

2) **Administrative Charges**

- a) Charges to complete claim forms,
- b) Charges to get medical records or reports,
- c) Membership, administrative, or access fees charged by Doctors or other Providers. Examples include, but are not limited to, fees for educational brochures or calling you to give you test results.

3) **Alternative / Complementary Medicine**

- Services or supplies for alternative or complementary medicine, regardless of the Provider rendering such services or supplies. This includes, but is not limited to:

- a. Holistic medicine,
- b. Homeopathic medicine,
- c. Hypnosis,
- d. Aroma therapy,
- e. Reiki therapy,
- f. Herbal, vitamin or dietary products or therapies,
- g. Naturopathy,
- h. Thermography,
- i. Orthomolecular therapy,
- j. Contact reflex analysis,
- k. Bioenergetic synchronization technique (BEST),
- l. Iridology-study of the iris,
- m. Auditory integration therapy (AIT),
- n. Colonic irrigation,
- o. Magnetic innervation therapy,

- p. Electromagnetic therapy,
- q. Neurofeedback / Biofeedback.

- 4) **Applied Behavioral Treatment** - (including, but not limited to, Applied Behavior Analysis and intensive behavior interventions) for all indications except as described under Autism Services.
- 5) **Before Effective Date or After Termination Date** - Charges for care you get before your Effective Date or after your coverage ends, except as written in this Plan.
- 6) **Certain Providers** - Services you get from Providers that are not licensed by law to provide Covered Services as defined in this Booklet, or which are not recognized by us as an eligible Provider under this Plan.
- 7) **Charges Over the Maximum Allowed Amount** - Charges over the Maximum Allowed Amount for Covered Services, except as written in this Plan.
- 8) **Charges Not Supported by Medical Records** - Charges for services not described in your medical records.
- 9) **Clinically-Equivalent Alternatives** - Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.
- 10) **Collegiate Sports** - Charges for services related to injuries or illness sustained while participating in, practicing for or travelling to or from, an intercollegiate sport or competition. Additionally, Covered Services does not include expenses covered or eligible for coverage under any separate NCAA-sponsored or sanctioned insurance policy for student athletes.
- 11) **Complications of Non-Covered Services** - Care for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.
- 12) **Cosmetic Services** - Treatments, services, Prescription Drugs, equipment, or supplies given for cosmetic services. Cosmetic services are meant to preserve, change, or improve how you look or are given for psychiatric, psychological, or social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).
- 13) **Court Ordered Testing** - Court ordered testing or care unless the testing or care is Medically Necessary and otherwise a Covered Service under this Booklet.
- 14) **Crime** - Treatment of an injury or illness that results from a crime you committed, or tried to commit. This Exclusion does not apply if your involvement in the crime was solely the result of a medical or mental condition, or where you were the victim of a crime, including domestic violence.
- 15) **Custodial Care** - Custodial Care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.
- 16) **Delivery Charges** - Charges for delivery of Prescription Drugs.
- 17) **Dental Services**
 - a) Dental care for Members age 19 or older, unless listed as covered in the medical benefits of this Booklet.
 - b) Dental services or health care services not specifically covered in this Booklet (including any hospital charges, prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code, unless covered by the medical benefits of this Plan).
 - c) Services of anesthesiologists, unless required by law.
 - d) Analgesia, analgesia agents, oral sedation, and anxiolysis nitrous oxide.
 - e) Anesthesia services (such as intravenous conscious sedation, IV sedation and general anesthesia) are not covered when given separate from a covered oral surgery service. EXCEPTION: General anesthesia for dental services for members under age 19 years of age when rendered in a hospital, outpatient surgical facility or other facility licensed pursuant to Section 25-3-101 of the Colorado Revised Statutes if the child, in the opinion of the treating Dentist, satisfies one or more of the following criteria: (a) the child has a physical, mental, or medically compromising condition; (b) the child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; (c) the child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or (d) the child has sustained extensive orofacial and dental trauma.

- f) Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. Includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
 - g) Dental services or supplies provided solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
 - h) Occlusal or athletic mouth guards.
 - i) Prosthodontic services (such as dentures or bridges) and periodontal services such as scaling and root planing).
 - j) For members through age 18, prosthodontic services (such as dentures or bridges) and periodontal services (such as scaling and root planing).
 - k) Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
 - l) Separate services billed when they are an inherent component of another covered service.
 - m) Services to treat Temporomandibular Joint Disorder (TMJ) except as covered under your medical coverage.
 - n) Oral hygiene instructions.
 - o) Case presentations, office visits and consultations.
 - p) Implant services, except as listed in this Booklet.
 - q) Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling materials, nor the procedures used to prepare and place material(s) in the canals (tooth roots).
 - r) Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
 - s) Incomplete root canals.
 - t) Adjunctive diagnostic tests.
- 18) **Drugs That Do Not Need a Prescription** - Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- 19) **Drugs Prescribed by Providers Lacking Qualifications/Certifications** - Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, including certifications, as determined by Anthem.
- 20) **Educational Services** - Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Booklet.
- 21) **Experimental or Investigational Services** - Services or supplies that we find are Experimental / Investigational. This also applies to services related to Experimental / Investigational services, whether you get them before, during, or after you get the Experimental / Investigational service or supply.
- The fact that a service or supply is the only available treatment will not make it Covered Service if we conclude it is Experimental / Investigational.
- 22) **Eyeglasses and Contact Lenses** - Eyeglasses and contact lenses to correct your eyesight unless listed as covered in this Booklet. This Exclusion does not apply to lenses needed after a covered eye surgery.
- 23) **Eye Exercises** - Orthoptics and vision therapy.
- 24) **Eye Surgery** - Eye surgery to fix errors of refraction, such as near-sightedness. This includes, but is not limited to, LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratotomy.
- 25) **Family Members** - Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- 26) **Foot Care** - Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
- a) Cleaning and soaking the feet.
 - b) Applying skin creams to care for skin tone.
 - c) Other services that are given when there is not an illness, injury or symptom involving the foot.
- 27) **Foot Orthotics** - Foot orthotics, orthopedic shoes or footwear or support items unless used for an illness affecting the lower limbs, such as severe diabetes.
- 28) **Foot Surgery** - Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- 29) **Free Care** - Services you would not have to pay for if you didn't have this Plan. This includes, but is not limited to government programs, services during a jail or prison sentence, services you get from Workers Compensation, and services from free clinics.
- If Workers' Compensation benefits are not available to you, this Exclusion does not apply. This Exclusion will apply if you get the benefits in whole or in part.
- 30) **Gene Therapy** - Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- 31) **Hearing Aids** - Hearing aids or exams to prescribe or fit hearing aids, unless listed as covered in this Booklet. This Exclusion does not apply to cochlear implants.
- 32) **Health Club Memberships and Fitness Services** - Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a Doctor. This Exclusion also applies to health spas.
- 33) **Infertility Treatment** - Infertility procedures not specified in this Booklet.
- 34) **Intractable Pain and/or Chronic Pain** - Charges for a pain state in which the cause of the pain cannot be removed and which in the course of medical practice no relief or cure of the cause of the pain is possible, or none has been found after reasonable efforts. It is pain that lasts more than 6 months, is not life threatening, and may continue for a lifetime, and has not responded to current treatment.
- 35) **Lost or Stolen Drugs** - Refills of lost or stolen Drugs.
- 36) **Maintenance Therapy** - Rehabilitative treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better. This Exclusion does not apply to "Habilitative Services".
- 37) **Medical Equipment, Devices, and Supplies**
- a) Replacement or repair of purchased or rental equipment because of misuse, or loss.
 - b) Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - c) Non-Medically Necessary enhancements to standard equipment and devices.
 - d) Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that

exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility.

- 38) **Medicare** - For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this Booklet or as required by federal law, as described in the section titled "Medicare" in "General Provisions". If you do not enroll in Medicare Part B, We will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
- 39) **Missed or Cancelled Appointments** - Charges for missed or cancelled appointments.
- 40) **Non-Medically Necessary Services** - Services we conclude are not Medically Necessary. This includes services that do not meet our medical policy, clinical coverage, or benefit policy guidelines.
- 41) **Nutritional or Dietary Supplements** - Nutritional and/or dietary supplements, except as described in this Booklet or that we must cover by law. This Exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist.
- 42) **Off label use** - Off label use, unless we must cover it by law or if we approve it.
- 43) **Oral Surgery** - Extraction of teeth, surgery for impacted teeth, jaw augmentation or reduction (orthognathic Surgery), and other oral surgeries to treat the teeth, jaw or bones and gums directly supporting the teeth, except as listed in this Booklet.
- 44) **Personal Care and Convenience**
- Items for personal comfort, convenience, protection, cleanliness such as air conditioners, humidifiers, water purifiers, sports helmets, raised toilet seats, and shower chairs,
 - First aid supplies and other items kept in the home for general use (bandages, cotton-tipped applicators, thermometers, petroleum jelly, tape, non-sterile gloves, heating pads),
 - Home workout or therapy equipment, including treadmills and home gyms,
 - Pools, whirlpools, spas, or hydrotherapy equipment.
 - Hypo-allergenic pillows, mattresses, or waterbeds,
 - Residential, auto, or place of business structural changes (ramps, lifts, elevator

- chairs, escalators, elevators, stair glides, emergency alert equipment, handrails).
- 45) **Private Duty Nursing** - Private Duty Nursing Services, except as specifically stated in this Booklet.
- 46) **Prosthetics** - Prosthetics for sports or cosmetic purposes. This includes wigs and scalp hair prosthetics.
- 47) **Residential accommodations** - Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential Treatment Center.
- 48) **Services Received From Student Health Center** - Services provided normally without charge by the Student Health Center of the Policyholder. Services covered or provided by the student health fee.
- 49) **Sexual Dysfunction** - Services or supplies for male or female sexual problems.
- 50) **Stand-By Charges** - Stand-by charges of a Doctor or other Provider.
- 51) **Sterilization** - Services to reverse an elective sterilization.
- 52) **Surrogate Mother Services** - Services or supplies for a person not covered under this Plan for a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- 53) **Temporomandibular Joint Treatment** - Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).
- 54) **Travel Costs** - Mileage, lodging, meals, and other Member-related travel costs except as described in this Plan.
- 55) **Vein Treatment** - Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.
- 56) **Vision Services**
- Vision services not specifically listed as covered in this Booklet.
 - For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacture does not allow discounts.
 - Safety glasses and accompanying frames.
 - For two pairs of glasses in lieu of bifocals.
 - Plano lenses (lenses that have no refractive power).
 - Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.

- Blended lenses.
 - Oversize lenses.
 - Sunglasses.
 - For Members through age 18, no benefits are available for frames and contact lenses purchased outside of our formulary.
 - Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically stated as covered in this Booklet.
 - Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.
- 57) **Waived Cost-Shares Out-of-Network** - For any service for which you are responsible under the terms of this Plan to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.
- 58) **Weight Loss Programs** - Programs, whether or not under medical supervision, unless listed as covered in this Booklet.
- This Exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
- 59) **Weight Loss Surgery** - Services and supplies related to bariatric surgery, or surgical treatment of obesity, unless listed as covered in the Booklet.

What's Not Covered Under Your Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy Benefit

In addition to the above Exclusions, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

- Administration Charges** - Charges for the administration of any Drug except for covered immunizations as approved by us or the PBM.
- Clinically-Equivalent Alternatives** - Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.
- Compound Drugs** - Compound Drugs unless all of the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved

compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

4. **Contrary to Approved Medical and Professional Standards** - Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
5. **Delivery Charges** - Charges for delivery of Prescription Drugs.
6. **Drugs Given at the Provider's Office/Facility** - Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Prescription Drugs Administered by a Medical Provider" section, or Drugs covered under the "Medical and Surgical Supplies" benefit - they are Covered Services.
7. **Drugs Not on the Anthem Prescription Drug List** (a formulary) - You can get a copy of the list by calling us or visiting our website at www.anthem.com. If you or your Doctor believes you need a certain Prescription Drug not on the list, please refer to "Prescription Drug List" in the section "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" for details on requesting an exception.
8. **Drugs Over Quantity or Age Limits** - Drugs in quantities which are over the limits set by the Plan, or which are over any age limits set by us.
9. **Drugs Over the Quantity Prescribed or Refills After One Year** - Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
10. **Drugs Prescribed by Providers Lacking Qualifications/Certifications** - Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, including certifications, as determined by Anthem.
11. **Drugs That Do Not Need a Prescription** - Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
12. **Gene Therapy** - Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
13. **Infertility Drugs** - Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT), except as listed in this booklet.
14. **Items Covered as Durable Medical Equipment (DME)** - Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors. Items not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit may be covered under the "Durable Medical Equipment and Medical Devices" benefit. Please see that section for details.
15. **Items Covered Under the "Allergy Services" Benefit** - Allergy desensitization products or allergy serum. While not covered under the Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy benefit, these items may be covered under the "Allergy Services" benefit. Please see that section for details.
16. **Lost or Stolen Drugs** - Refills of lost or stolen Drugs.
17. **Mail Order** - Providers other than the PBM's Home Delivery Mail Order Provider Prescription Drugs dispensed by any Mail Order Provider other than the PBM's Home Delivery Mail Order Provider, unless we must cover them by law.
18. **Non-approved Drugs** - Drugs not approved by the FDA.
19. **Off label use** - Off label use, unless we must cover the use by law or if we, or the PBM, approve it.
20. **Onychomycosis Drugs** - Drugs for Onychomycosis (toenail fungus) except when we allow it to treat Members who are immunocompromised or diabetic.
21. **Over-the-Counter Items** - Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
This Exclusion does not apply to over-the-counter products that we must cover as a "Preventive Care" benefit under federal law with a Prescription.
22. **Sexual Dysfunction Drugs** - Drugs to treat sexual or erectile problems.
23. **Syringes** - Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
24. **Weight Loss Drugs** - Any Drug mainly used for weight loss.



Member Payment Responsibility

Your Cost-Shares

Your Plan may involve Copayments, Deductibles, and/or Coinsurance, which are charges that you must pay when receiving Covered Services. Your Plan may also have an Out-of-Pocket Limit, which limits the cost-shares you must pay. Please read the Schedule of Benefits for details on your cost shares. Also read the “Definitions” section for a better understanding of each type of cost share.

Maximum Allowed Amount

General

This section describes how we determine the amount of reimbursement for Covered Services. Except where specifically noted, reimbursement for services rendered by In-Network and Out-of-Network Providers is based on this Booklet’s Maximum Allowed Amount for the Covered Service that you receive. Please see “Inter-Plan Arrangements” in the “Claims Procedure (How to File a Claim)” section for additional information.

The Maximum Allowed Amount for this Booklet 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 your 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 your 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 an Out-of-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

When you receive Covered Services from a Provider, 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 received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding

rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Doctor 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 an In-Network Provider or an Out-of-Network Provider.

An In-Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence/or other closely managed specialty network, or who has a participation contract with us. For most Covered Services performed by an In-Network Provider, the Maximum Allowed Amount for this Booklet is the rate the Provider has agreed with us to accept as reimbursement for the Covered Services. Because In-Network 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 Services for help in finding an In-Network Provider or visit www.anthem.com.

Providers who have not signed any contract with us and are not in any of our networks are Out-of-Network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Booklet will be one of the following as determined by us:

1. An amount based on Anthem’s Out-of-Network Provider fee schedule/rate, which is established at Anthem’s discretion, and which Anthem may modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted

with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services (CMS) for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem 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 based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this product, but are contracted for other products with us are also considered Out-of-Network. For this Booklet, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between us and that Provider specifies a different amount.

For Covered Services rendered outside Anthem’s Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan’s non-participating provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price.

Unlike In-Network Providers, Out-of-Network 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 an In-Network Provider will likely result in lower out of pocket costs to you. Please call Member Services for help in finding an In-Network Provider or visit our website at www.anthem.com.

Member Services is also available to assist you in determining this Booklet's Maximum Allowed Amount for a particular service from an Out-of-Network 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 Services can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by us using Prescription Drug cost information provided by the Pharmacy Benefits Manager.

Member Cost Share

For certain Covered Services and depending on your Plan design, 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 received services from an In-Network or Out-of-Network Provider. Specifically, for some Covered Services, you may be required to pay higher cost sharing amounts or may have limits on your benefits when using Out-of-Network Providers. Please see the "Schedule of Benefits" in this Booklet for your cost share responsibilities and limitations, or call Member Services to learn how this Booklet's benefits 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 your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network or Out-of-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, 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 an Out-of-Network Provider. For example, if you go to an In-Network Hospital or Provider Facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with an In-Network Hospital or Facility, you will pay the In-Network cost share amounts for those Covered Services. You will not

have to pay more for the Covered Services than you would have had to pay if it had been received from an In-Network Provider.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits (Who Pays What)" for your applicable amounts.

Example: Your Plan has a Coinsurance cost share of 20% for In-Network services, and 30% for Out-of-Network services after the In-Network or Out-of-Network Deductible has been met.

You undergo a surgical procedure in an In-Network Hospital. The Hospital has contracted with an Out-of-Network anesthesiologist to perform the anesthesiology services for the surgery. You have no control over the anesthesiologist used.

- The Out-of-Network anesthesiologist's charge for the service is \$1200, your coinsurance responsibility is 20% of \$1200, or \$240.
- You choose an In-Network surgeon. The charge was \$2500. The Maximum Allowed Amount for the surgery is \$1500; your Coinsurance responsibility when an In-Network surgeon is used is 20% of \$1500, or \$300. We allow 80% of \$1500, or \$1200. The In-Network surgeon accepts the total of \$1500 as reimbursement for the surgery regardless of the charges. Your total out of pocket responsibility would be \$300.
- You choose an Out-of-Network surgeon. The Out-of-Network surgeon's charge for the service is \$2500. The Maximum Allowed Amount for the surgery service is \$1500; your Coinsurance responsibility for the Out-of-Network surgeon is 30% of \$1500, or \$450 after the Out-of-Network Deductible has been met. We allow the remaining 70% of \$1500, or \$1050. In addition, the Out-of-Network surgeon could bill you the difference between \$2500 and \$1500, so your total Out of Pocket charge would be \$450 plus an additional \$1000, for a total of \$1450.

Authorized Services

In some circumstances, such as where there is no In-Network Provider available, or if we don't have an In-Network Provider within a reasonable number of miles from your home, 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 an Out-of-Network Provider. In such circumstances, you must contact us in advance of obtaining the Covered

Service. If approved, we will pay the Out-of-Network Provider at the In-Network level of benefits and you won't need to pay more for the services than if the services had been received from an In-Network Provider. A Precertification or preauthorization is not the same thing as an Authorized Service; we must specifically authorize the service from an Out-of-Network Provider at the In-Network cost share amounts.

Sometimes you may need to travel a reasonable distance to get care from an In-Network Provider. This does not apply if care is for an Emergency.

If you do not receive a preauthorized network exception to obtain Covered Services from an Out-of-Network Provider at the In-Network cost share amounts, the claim will be processed using your Out-of-Network cost shares.

The following are examples for illustrative purposes only; the amounts shown may be different than this Booklet's cost share amounts; see your "Schedule of Benefits" for your applicable amounts.

Example:

You require the services of a specialty Provider; but there is no In-Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-of-Network Provider for that Covered Service and we agree that the In-Network cost share will apply.

Your Plan has a \$45 Copayment for Out-of-Network Providers and a \$25 Copayment for In-Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is \$500. The Maximum Allowed Amount is \$200.

Because we have authorized the In-Network cost share amount to apply in this situation, you will be responsible for the In-Network Copayment of \$25 and we will be responsible for the remaining \$475.

Claims Review

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

If a word or phrase in this Booklet has a special meaning, such as Medical Necessity or Experimental / Investigational, it will start with a capital letter, and be defined below. If you have questions on any of these definitions, please call Member Services at the number on the back of your Identification Card.

Accidental Injury

An unexpected Injury for which you need Covered Services while enrolled in this Plan. It does not include injuries that you get benefits for under any Workers' Compensation, Employer's liability or similar law.

Ambulatory Surgical Facility

A Facility, with a staff of Doctors, that:

1. Is licensed as required;
2. Has permanent facilities and equipment to perform surgical procedures on an Outpatient basis;
3. Gives treatment by or under the supervision of Doctors, and nursing services when the patient is in the Facility;
4. Does not have Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Doctor or other professional Provider.

Application

The document through which the University has applied for coverage under the Master Contract with us.

Applied Behavioral Analysis

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

Authorized Service(s)

A Covered Service you get from an Out-of-Network Provider that we have agreed to cover at the In-Network level. You will not have to pay any more than the In-Network Deductible, Coinsurance, and/or Copayment(s) that apply. Please see "Claims Procedure (How to File a Claim)" for more details.

Autism Services Provider

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

Autism Spectrum Disorders or ASD

Includes the following disorders, as defined in the most recent edition of the diagnostic and statistical manual of mental disorders in effect at the time of the diagnosis: autistic disorder, Asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified.

Autism Treatment Plan

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

Benefit Period

The length of time we will cover benefits for Covered Services. For Calendar Year plans, the Benefit Period starts on January 1st and ends on December 31st. For Plan Year plans, the Benefit Period starts on your University's effective or renewal date and lasts for 12 months. (See your University for details.)

Benefit Period Maximum

The most we will cover for a Covered Service during a Benefit Period.

Biosimilar/Biosimilars

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

Booklet

This document (also called the certificate), which describes the terms of your benefits. It is part of the Master Contract with your University, and is also subject to the terms of the Master Contract.

Brand Name Drug

Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Centers of Excellence (COE) Network

A network of health care facilities, which have been selected to give specific services to our Members based on their experience, outcomes, efficiency, and effectiveness. An In-Network Provider under this Plan is not necessarily a COE. To be a COE, the Provider must have signed a Center of Excellence Agreement with us.

Chiropractic Care / Manipulation Therapy

A system of therapy that includes the therapeutic application of manual manipulation treatment, analysis and adjustments of the spine and other body structures, and muscle stimulation by any means, including therapeutic use of heat, cold, and exercise.

Closed Panel Plan

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

Coinsurance

Your share of the cost for Covered Services, which is a percent of the Maximum Allowed Amount. You normally pay Coinsurance after you meet your Deductible. For example, if your Plan lists 20% Coinsurance on office visits, and the Maximum Allowed Amount is \$100, your Coinsurance would be \$20 after you meet the Deductible. The Plan would then cover the rest of the Maximum Allowed Amount. Your Coinsurance will not be reduced by any refunds, rebates, or any other form of negotiated post-payment adjustments.

Complications of Pregnancy

Complications of Pregnancy means:

- Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. This does not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy;
- Non-elective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

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.

Copayment

A fixed amount you pay toward a Covered Service. You normally have to pay the Copayment when you get health care. The amount can vary by the type of Covered Service you get. For example, you may have to pay a \$15 Copayment for an office visit, but a \$150 Copayment for Emergency Room Services.

Covered Services

Health care services, supplies, or treatment described in this Booklet that are given to you by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or specifically included as a benefit under this Booklet.
- Within the scope of the Provider's license.
- Given while you are covered under the Plan.
- Not Experimental / Investigational, excluded, or limited by this Booklet, or by any amendment or rider to this Booklet.
- Approved by us before you get the service if prior authorization is needed.

A charge for a Covered Service will apply on the date the service, supply, or treatment was given to you.

Covered Services do not include services or supplies not described in the Provider records.

Covered Transplant Procedure

As decided by us, any Medically Necessary human organ, tissue, and stem cell / bone marrow transplants and infusions including 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.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further.

Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers.

Examples of Custodial Care include:

- Help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet,

- Changing dressings of non-infected wounds, after surgery or chronic conditions,
 - Preparing meals and/or special diets,
 - Feeding by utensil, tube, or gastrostomy,
 - Common skin and nail care,
 - Supervising medicine that you can take yourself,
 - Catheter care, general colostomy or ileostomy care,
 - Routine services which we decide can be safely done by you or a non-medical person without the help of trained medical and paramedical workers,
 - Residential care and adult day care,
 - Protective and supportive care, including education,
 - Rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible

The amount you must pay for Covered Services before benefits begin under this Plan. For example, if your Deductible is \$1,000, your Plan won't cover anything until you meet the \$1,000 Deductible. The Deductible may not apply to all Covered Services.

Dentally Necessary Orthodontic Care

A service for pediatric members used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for Dentally Necessary Orthodontic Care to be covered. Note: For adult orthodontic services for cleft lip and cleft palate conditions, see the Dental Services (All Members / All Ages) description.

Designated Pharmacy Provider

An In-Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with us or an In-Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

Doctor

See the definition of "Physician."

Early Intervention Services

Services, as defined by Colorado law in accordance with part C, that are authorized through an Eligible Child's IFSP but that exclude: nonemergency medical transportation; respite care; service coordination, as defined in federal law; and assistive technology (unless covered under this Booklet as durable medical equipment).

- Eligible Child - means an infant or toddler, from birth through two years of age, who is an eligible Dependent and who, as defined by Colorado law,

has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for services pursuant to Colorado law.

- Individualized family service plan or IFSP - means a written plan developed pursuant to federal law that authorizes early intervention services to an Eligible Child and the child's family. An IFSP shall serve as the individualized plan for an Eligible Child from birth through two years of age.

Effective Date

The date your coverage begins under this Plan.

Emergency Care

"Emergency Care" means a medical or behavioral health exam done in the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Medical Condition. It includes any further medical or behavioral health exams and treatment required to stabilize the patient.

Enrollment Date

The first day you are covered under the Plan.

Excluded Services (Exclusion)

Health care services your Plan doesn't cover.

Experimental or Investigational (Experimental / Investigational)

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

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

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

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use;
- Is provided as part of a clinical research protocol or clinical trial (except as noted in the Clinical Trials section under Covered Services in this Booklet as required by state law), or is provided

in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

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

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

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

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

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

- Documents of an IRB or other similar body performing substantially the same function;
 - Consent documentation(s) used by the treating Physicians, other medical professionals or facilities, or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply;
 - The written protocol(s) used by the treating Physicians, other medical professionals or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply;
 - Medical records; or
 - The opinions of consulting Providers and other experts in the field.
- (d) We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental or Investigational.

Facility

A facility including but not limited to, a Hospital, freestanding Ambulatory Surgical Facility, Chemical Dependency Treatment Facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this Booklet. The Facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable or meet specific rules set by us.

Generic Drugs

Prescription Drugs that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Habilitative Services

Habilitative Services help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age.

Home Health Care Agency

A Facility, licensed in the state in which it is located, that:

1. Gives skilled nursing and other services on a visiting basis in your home; and

2. Supervises the delivery of services under a plan prescribed and approved in writing by the attending Doctor.

Hospice

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

Hospital

A Provider licensed and operated as required by law, which has:

1. Room, board, and nursing care;
2. A staff with one or more Doctors on hand at all times;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury; and
5. Is fully accredited by The Joint Commission.

The term Hospital 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
7. Subacute care
8. Treatment of alcohol abuse
9. Treatment of drug abuse
10. Treatment of Students of the University

Identification Card

The card we give you that shows your Member identification, group numbers, and the plan you have.

In-Network Provider

A Provider that has a contract, either directly or indirectly, with us, or another organization, to give Covered Services to Members through negotiated payment arrangements.

In-Network Transplant Provider

A Provider that we have chosen as a Center of Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association. The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network.

Inpatient

A Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

Intensive In-Home Behavioral Health Services

A range of therapy services provided in the home to address symptoms and behaviors that, as the result of a mental disorder or substance use disorder, put the Members and others at risk of harm.

Intensive Outpatient Program

Short-term behavioral health treatment that provides a combination of individual, group and family therapy.

Interchangeable Biologic Product

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

Master Contract

The Contract between us, Anthem, and the University (also known as the Master Contract). It includes this Booklet, your application, any application or change form, your Identification Card, any endorsements, riders or amendments, and any legal terms added by us to the original Contract.

The Master Contract is kept on file by the University. If a conflict occurs between the Master Contract and this Booklet, the Master Contract controls.

Maximum Allowed Amount

The maximum payment that we will allow for Covered Services. For more information, see the "Member Payment Responsibility" section.

Medical Necessity (Medically Necessary)

The diagnosis, evaluation and treatment of a condition, illness, disease or injury that we solely decide to be:

- Medically appropriate for and consistent with your symptoms and proper diagnosis or treatment of your condition, illness, disease or injury;
- Obtained from a Doctor or Provider;
- Provided in line with medical or professional standards;
- Known to be effective, as proven by scientific evidence, in improving health;
- The most appropriate supply, setting or level of service that can safely be provided to you

and which cannot be omitted. It will need to be consistent with recognized professional standards of care. In the case of a Hospital stay, also means that safe and adequate care could not be obtained as an outpatient;

- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of your illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- Not Experimental or Investigational;
- Not primarily for you, your families, or your Provider's convenience; and
- Not otherwise an exclusion under this Booklet.

The fact that a Doctor or Provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary.

Member

People, including the Student, who have met the eligibility rules, applied for coverage, and enrolled in the Plan. Members are called "you" and "your" in this Booklet.

Member Services

The resource you can call with questions about your coverage. Member Services may be handled by Anthem or another party. To contact Member Services, dial the number on the back of your Identification Card.

Mental Health, Biologically Based Mental Illness and Substance Abuse

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

Minimum Essential Coverage

The term Minimum Essential Coverage means any of the following: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Out-of-Network Provider

A Provider that does not have an agreement or contract with us, or our subcontractor(s) to give services to our Members.

You will often get a lower level of benefits when you use Out-of-Network Providers.

Out-of-Network Transplant Provider

Please see the Schedule of Benefits section for details.

Out-of-Pocket Limit

The most you pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket limit does not include your Premium, amounts over the Maximum Allowed Amount, out-of-network transplant services or charges for health care that your Plan doesn't cover. Please see the Schedule of Benefits section for details.

Partial Hospitalization Program

Structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

Pharmacy

A place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Process

A process to make clinically based recommendations that will help you access quality, low cost medicines within your Plan. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Physician (Doctor)

Includes the following when licensed by law:

- Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery,
- Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O.,
- Doctor of Chiropractic (D.C.), legally licensed to perform the duties of a chiropractor;
- Doctor of Podiatric Medicine (D.P.M.) legally

entitled to practice podiatry, and

- Doctor of Dental Medicine (D.D.M.), Doctor of Dental Surgery (D.D.S.), legally entitled to provide dental services.

Optometrists, Clinical Psychologists (PhD), and surgical chiropodists are also Providers when legally licensed and giving Covered Services within the scope of their licenses.

Plan and Plan Year

Plan means the benefit plan the University has purchased, which is described in this Booklet. The Plan Year means the period of time by which the University renews its Master Contract with us.

Precertification

Please see the section “How to Access Your Services and Obtain Approval of Benefits” for details.

Premium

The amount that you must pay to be covered by this Plan. This may be based on your age and will depend on the University’s Contract with us.

Prescription Drug (Drug) (Also referred to as Legend Drug)

A medicine that is approved by the Food & Drug Administration (FDA) to treat an illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1. Compounded (combination) medications, when all of the ingredients are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.
2. Insulin, diabetic supplies, and syringes.

Primary Care Physician / Provider (“PCP”)

A Provider who gives or directs health care services for you. The Provider may work in family practice, general practice, internal medicine, pediatrics or any other practice allowed by the Plan.

Provider

A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by us. This includes any Provider that state law says we must cover when they give you services that state law says we must cover. Providers that deliver Covered Services are described throughout this Booklet. If you have a question about a Provider

not described in this Booklet please call the number on the back of your Identification Card.

Qualified Early Intervention Service Provider

Means a person or agency, as defined by Colorado law in accordance with part C, who provides Early Intervention Services and is listed on the registry of early intervention service providers.

Referral

Please see the “How to Access Services and Obtain Approval of Benefits” section for details.

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 (COA).

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

Retail Health Clinic

A Facility that gives limited basic health care services to Members on a “walk-in” basis. These clinics are often found in major pharmacies or retail stores. Medical services are typically given by Physician Assistants and Nurse Practitioners.

Service Area

The geographical area where you can get Covered Services from an In-Network Provider.

Skilled Nursing Facility

A duly licensed Facility operated alone or with a Hospital that cares for you 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:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a Doctor;
3. 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 Enrollment

A period of time in which eligible people or can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc. See the “Eligibility” section for more details.

Specialist

(Specialty Care Physician \ Provider or SCP)

A Specialist is a Doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

Specialty Drugs

Drugs that typically need close supervision and checking of their effect on the patient by a medical professional. These drugs often need special handling, such as temperature-controlled packaging and overnight delivery, and are often not available at retail pharmacies. They may be administered in many forms including, but not limited to, injectable, infused, oral and inhaled.

Student

A student who is eligible for and has enrolled in the Plan according to the rules stated under the “Eligibility” section.

Transplant Benefit Period

Please see the Schedule of Benefits section for details.

University or School

The educational institution which has a Master Contract with us, Anthem, and which sponsors this Plan.

Urgent Care Center

A licensed health care Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for urgent care.

Utilization Review

A set of formal techniques to monitor 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 reviewing whether or not a procedure or treatment is considered Experimental or Investigational, and reviewing your medical circumstances when such a review is needed to determine if an exclusion applies.



Information regarding what is covered (benefits) and not covered, Limitations and Exclusions, Notice of Appeal Rights, Definition of Terms, and other medical plan details may be found in the member Certificate as well as the Summary of Benefits and Coverage (and its Supplement). You have a right to access information about your health plan at any time. Please visit <https://www.coloradocollege.edu/offices/studenthealthcenter/insurance/>

Standard Internal Appeal

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person's Designated Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination. In order to secure an Internal Review after the receipt of the notification of a benefit denied due to a contractual exclusion, the Insured Person must be able to provide evidence from a medical professional that there is a reasonable medical basis that the policy exclusion does not apply to the denied benefit.

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The Provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 1-844-274-6385 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: Anthem Blue Cross and Blue Shield, Appeals Department, 700 Broadway CO0104-0430, Denver, CO 80273

Expedited Internal Appeal

For Urgent Care Requests, an Insured Person or a Designated Representative may submit a request, either orally or in writing, for an Expedited Internal Appeal (EIR) of an Adverse Determination:

1. involving Urgent Care Requests; and
2. related to a concurrent review Urgent Care Request involving an admission, availability of care, continued stay or health care service for an Insured Person who has received emergency services, but has not been discharged from a facility.

All necessary information, including the Company's decision, shall be transmitted to the Insured Person or a Designated Representative via telephone, facsimile or the most expeditious method available. The Insured Person or the Designated Representative shall be notified of the EIR decision no more than seventy-two (72) hours after the Company's receipt of the EIR request.

If the EIR request is related to a concurrent review Urgent Care Request, benefits for the service will continue until the Insured Person has been notified of the final determination.

At the same time an Insured Person or a Designated Representative files an EIR request, the Insured Person or the Designated Representative may file:

1. An Expedited External Review (EER) request if the Insured Person has a medical condition where the timeframe for completion of an EIR would seriously jeopardize the life or health of the Insured Person or would jeopardize the Insured Person's ability to regain maximum function; or
2. An Expedited Experimental or Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage based on the a determination that the recommended or requested service or treatment is experimental or investigational and the Insured Person's treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

To request an Expedited Internal Appeal, please contact Claims Appeals at 1-844-274-6385. The written request for an Expedited Internal Appeal should be sent to: Anthem Blue Cross and Blue Shield, Appeals Department, 700 Broadway CO0104-0430, Denver, CO 80273

Right to External Independent Review

After exhausting the Company's Internal Appeal process, the Insured Person, or the Insured Person's Designated Representative, has the right to request an External Independent Review when the service or treatment in question:

1. Is a Covered Medical Expense under the Policy; and
2. Is not covered because it does not meet the Company's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, or the treatment is determined to be experimental or investigational.

Standard External Review

A Standard External Review request must be submitted in writing within 4 months of receiving a notice of the Company's Adverse Determination or Final Adverse Determination.

Expedited External Review

An Expedited External Review request may be submitted either orally or in writing when:

1. The Insured Person or the Insured Person's Designated Representative has received an Adverse Determination, and
 - a. The Insured Person, or the Insured Person's Designated Representative, has submitted a request for an Expedited Internal Appeal; and
 - b. Adverse Determination involves a medical condition for which the time frame for completing an Expedited Internal Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
2. The Insured Person or the Insured Person's Designated Representative has received a Final Adverse Determination, and
 - a. The Insured Person has a medical condition for which the time frame for completing a Standard External Review would seriously jeopardize the life or health of the Insured Person or jeopardize the Insured Person's ability to regain maximum function; or
 - b. The Final Adverse Determination involves an admission, availability of care, continued stay, or health care service for which the Insured Person received emergency services, but has not been discharged from a facility.

The Insured Person or Insured Person's Designated Representative's request for an Expedited External Review must include a Physician's Certification that the Insured Person's medical condition meets the above criteria.

An EER may not be provided for retrospective Adverse Determinations or Final Adverse Determinations.

Where to Send External Review Requests

All types of External Review requests shall be submitted to the Company at the following address:

Anthem Blue Cross and Blue Shield
Appeals Department
700 Broadway CO0104-0430
Denver, CO 80273

Questions Regarding Appeal Rights

Contact Customer Service at 1-844-274-6385 with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

The Plan is Underwritten by:

Anthem Inc.
Administrative Office:
AmeriBen
P.O. Box 6947
Boise, ID 83707
855-258-6450
Email: webinquiries@ameriben.com
www.myameriben.com

Sales/Marketing Services:

Specialty Insurance Solutions, Inc.
16201 West 95th Street, Suite 210,
Lenexa, KS 66219
877-974-7462 ext. 100
E-mail: Student-Insurance@sis-inc.biz

Please keep this Brochure as a general summary of the insurance. The Master Policy on file at the University contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. The Master Policy is the contract and will govern and control the payment of benefits.

This Brochure is based on Policy # 196614M001



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This Brochure is based on Policy # 196614M001.

Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-234-0111 or visiting us at www.anthem.com.

Insurance Company:
Anthem Inc.
Policy Number:
196614M001

ADMINISTERED BY:
AmeriBen
P.O. Box 6947
Boise, ID 83707-0947
Toll Free - 855-258-6450
Fax - Please call for reference number
www.myameriben.com
Hours of Operation: 7:00 a.m. to 6:00 p.m.
Mountain Time



**COLORADO
COLLEGE**

Colorado Springs, CO 80903

Colorado College is an equal opportunity/affirmative action institution and complies with all Federal and Colorado State laws, regulations, and executive orders regarding affirmative action requirements in all programs. The Office of Equal Opportunity is located in 101 Student Services. In order to assist Colorado College in meeting its affirmative action responsibilities, ethnic minorities, women, and other protected class members are encouraged to apply and to so identify themselves.