Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
Lumenos® Health Savings Account (HSA-Compatible) 2000 Plan 18

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but the patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

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

	IN-NETWORK	OUT-OF-NETWORK
4. Deductible Type[2]	Calendar Year	
4a. ANNUAL DEDUCTIBLE[2a] a) Single[2b]	$2,000 per individual	
b) Non-single[2c]	$4,000 per individual or family If you select family membership, no individual deductible applies and the family deductible must be met before Anthem provides benefits. The family deductible amount is met as follows: when one individual has satisfied the family deductible, that family member and all other family members are eligible for benefits.	
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] a) Individual	$2,000 per individual, includes deductible and coinsurance.	$4,000 per individual, includes deductible and coinsurance.
b) Family	$4,000 per individual or family, includes deductible and coinsurance. If you select family membership, no individual out-of-pocket annual maximum applies and the family out-of-pocket annual maximum must be met before Anthem provides benefits. The family out-of-pocket annual maximum amount is met as follows: when one individual has satisfied the family out-of-pocket maximum, that family member and all other family members are eligible for benefits.	$8,000 per individual or family, includes deductible and coinsurance. If you select family membership, no individual out-of-pocket annual maximum applies and the family out-of-pocket annual maximum must be met before Anthem provides benefits. The family out-of-pocket annual maximum amount is met as follows: when one individual has satisfied the family out-of-pocket maximum, that family member and all other family members are eligible for benefits.
c) Is deductible included in the out-of-pocket maximum?	Yes	Yes

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

	IN-NETWORK	OUT-OF-NETWORK
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$6,000,000 per member for most covered services, in- and out-of-network combined. Infertility diagnostic services have a lifetime maximum benefit of $2,000 per member in- and out-of-network combined. Bariatric surgery has a lifetime maximum benefit of $7,500 per member for services received from a designated facility; total lifetime maximum payment shall not exceed $7,500 per member in- and out-of-network combined.	$6,000,000 per member for most covered services, in- and out-of-network combined. Infertility diagnostic services have a lifetime maximum benefit of $2,000 per member in- and out-of-network combined. Bariatric surgery has a lifetime maximum benefit of $1,500 per member for services received from a facility that is not a designated facility; total lifetime maximum payment shall not exceed $7,500 per member in- and out-of-network combined.
7A. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list of current providers.	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes
8. MEDICAL OFFICE VISITS[4]		
a) Primary Care Providers	Covered person pays no coinsurance (100% covered) after deductible.	Covered person pays 30% coinsurance after deductible.
b) Specialists	Covered person pays no coinsurance (100% covered) after deductible.	Covered person pays 30% coinsurance after deductible.
9. PREVENTIVE CARE		
a) Children's services	**Up to age 13:** Covered person pays no coinsurance (100% covered), not subject to deductible.	**Up to age 13:** Covered person pays 30% coinsurance, not subject to deductible.
b) Adults' services	**Age 13 and above:** Covered person pays no coinsurance (100% covered), not subject to deductible.	**Age 13 and above mammogram and prostate screenings:** Covered person pays 30% coinsurance, not subject to deductible. **Age 13 and above all other covered services:** Covered person pays 30% coinsurance after deductible.
10. MATERNITY		
a) Prenatal care	Covered person pays no coinsurance (100% covered) after deductible.	Covered person pays 30% coinsurance after deductible.
b) Delivery & inpatient well baby care[5]	Covered person pays no coinsurance (100% covered) after deductible.	Covered person pays 30% coinsurance after deductible.
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions[6]		
a) Inpatient care	Covered person pays no coinsurance (100% covered) after deductible.	Covered person pays 30% after deductible.
b) Outpatient care	**Retail Pharmacy Drugs:** Covered person pays no coinsurance (100% covered) after deductible for up to a 30-day supply.	**Retail Pharmacy Drugs:** Covered person pays 30% coinsurance after deductible for up to a 30-day supply.
c) Prescription Mail Service	**Mail-Order Pharmacy Drugs:** Covered person pays no coinsurance (100% covered) after deductible for up to a 90-day supply. For information on prescription drugs, call customer service at 888-224-4911.	Not covered

	IN-NETWORK	OUT-OF-NETWORK
12. INPATIENT HOSPITAL	Covered person pays no coinsurance (100% covered) after deductible.	Covered person pays 30% coinsurance after deductible.
13. OUTPATIENT/AMBULATORY SURGERY	Covered person pays no coinsurance (100% covered) after deductible.	Covered person pays 30% coinsurance after deductible.
14. LABORATORY AND X-RAY	Covered person pays no coinsurance (100% covered) after deductible.	Covered person pays 30% coinsurance after deductible.
15. EMERGENCY CARE[7,8]	Covered person pays no coinsurance (100% covered) after deductible.	Covered person pays no coinsurance (100% covered) after deductible.
16. AMBULANCE	Covered person pays no coinsurance (100% covered) after deductible.	Covered person pays no coinsurance (100% covered) after deductible.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	Covered person pays no coinsurance (100% covered) after deductible.	Covered person pays 30% coinsurance after deductible.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE		
a) Inpatient care	Covered person pays no coinsurance (100% covered) after deductible. Limited to 45 full or 90 partial days per calendar year combined with alcohol abuse benefits (see line 20).	Not covered
b) Outpatient care	Covered person pays no coinsurance (100% covered) after deductible. Limited to 30 visits with a minimum of $1,000 in benefits per calendar year.	Not covered
20. ALCOHOL & SUBSTANCE ABUSE		
a) Inpatient Care	**Alcohol abuse:** Covered person pays no coinsurance (100% covered) after deductible. Limited to 45 full days per calendar year or 90 partial days per calendar year combined with mental health benefits (see line 19).	Not covered
	Substance abuse: Covered person pays no coinsurance (100% covered) after deductible. Limited to 30 days per calendar year or 60 days per lifetime.	Not covered
b) Outpatient care	Covered person pays no coinsurance (100% covered) after deductible. Limited to 20 visits with a minimum of $500 in benefits per calendar year for alcohol abuse; limited to 15 visits per calendar year for substance abuse.	Not covered
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY		
a) Inpatient	Covered person pays no coinsurance (100% covered) after deductible. Limited to 30 inpatient rehabilitation days per calendar year in- and out-of-network combined.	Covered person pays 30% coinsurance after deductible. Limited to 30 inpatient rehabilitation days per calendar year in- and out-of-network combined.
b) Outpatient	Covered person pays no coinsurance (100% covered) after deductible. Limited to 20 visits each per calendar year for physical, occupational and speech therapy in and out-of-network combined.	Covered person pays 30% coinsurance after deductible. Limited to 20 visits each per calendar year for physical, occupational and speech therapy in and out-of-network combined.

	IN-NETWORK	OUT-OF-NETWORK
22. DURABLE MEDICAL EQUIPMENT	Covered person pays no coinsurance (100% covered) after deductible with benefits limited to a maximum payment of $3,000 by Anthem per calendar year combined with oxygen (see line 23). The $3,000 maximum payment is combined to include Durable Medical Equipment (line 22) and Oxygen (line 23). For prosthetic devices (arms and legs), benefits are provided with the same deductible and coinsurance as provided by Medicare. Prosthetic devices for arms and legs are not subject to, or limited by, the maximum payment of $3,000 but a claim for such a device will reduce the $3,000 maximum payment for other Durable Medical Equipment and Oxygen services. Wigs for alopecia resulting from chemotherapy and radiation therapy up to a maximum benefit of $500 per member per year.	Not covered
23. OXYGEN	Covered person pays no coinsurance (100% covered) after deductible. Limited to a maximum benefit of $3,000 per calendar year, combined with durable medical equipment (see line 22).	Not covered
24. ORGAN TRANSPLANTS	Covered person pays no coinsurance (100% covered) after deductible.	Not covered
25. HOME HEALTH CARE	Covered person pays no coinsurance (100% covered) after deductible. Limited to 100 visits per calendar year.	Not covered
26. HOSPICE CARE	**Inpatient:** Covered person pays no coinsurance (100% covered) after deductible. **Outpatient:** Covered person pays no coinsurance (100% covered) after deductible.	**Inpatient:** Covered person pays 30% coinsurance after deductible. **Outpatient:** Covered person pays 30% coinsurance after deductible.
27. SKILLED NURSING FACILITY CARE	Covered person pays no coinsurance (100% covered) after deductible. Limited to 100 days per calendar year in- and out-of-network combined.	Covered person pays 30% coinsurance after deductible. Limited to 100 days per calendar year in- and out-of-network combined.
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Not covered	Not covered
30. CHIROPRACTIC CARE	Covered person pays no coinsurance (100% covered) after deductible. Limited to 12 visits per calendar year combined with acupuncture care (see line 31).	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	**Acupuncture care:** Covered person pays no coinsurance (100% covered) after deductible. Limited to 12 visits per calendar year combined with chiropractic care (see line 30). Members who desire another professional opinion may obtain a second surgical opinion.	Not covered Members who desire another professional opinion may obtain a second surgical opinion.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[10]	6 or 18 months for all pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining preauthorization.	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
39. What is the main customer service number?	888-224-4911	
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273 888-224-4911	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form # 06-00362 Small Group	
43. Does the plan have a binding arbitration clause?	Yes	

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

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

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

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

covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

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

[4] Medical office visits include physician, mid-level practitioner, and specialist visits.

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

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

[7] "Emergency care" means all services delivered in an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb threatening emergency existed.
[8] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

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

[10] Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

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

Anthem Blue Cross and Blue Shield & HMO Colorado
Health Benefit Plan Description Form Disclosure Amendment

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

Pursuant to Colorado law (C.R.S. §10-16-107(7)(a), services or supplies for the treatment of Intractable Pain and/or Chronic Pain are not covered.

Pursuant to Colorado law (C.R.S. §10-16-105(5)(g)(I)), small employers purchasing any health benefit plan other than a Basic Health Benefit Plan, must pay for all benefits mandated by Colorado law, including nonwaivable coverages for: newborn, maternity, pregnancy, childbirth, complications from pregnancy and childbirth, therapies for congenital defects and birth abnormalities, low-dose mammography, mental illness, biologically-based mental illness, the availability of alcoholism treatment, the availability of hospice care, prostate cancer screening, child health supervision services, hospitalization and general anesthesia for dental procedures for dependent children, diabetes, and prosthetic devices.

Pursuant to Colorado law (C.R.S. §10-16-105(5)(g)(II)), small employers purchasing a Basic Health Benefit Plan is waiving coverage for low-dose mammography screening, mental illness, prostate cancer screening, hospitalization and general anesthesia for dental procedures for children, and the availability of treatment for alcoholism. All other state-mandated benefits are included in the Basic Health Benefit Plan.

This coverage is renewable at your option, except for the following reasons:

1. **Non-payment of the required premium;**
2. **Fraud or intentional misrepresentation of material fact on the part of the plan sponsor;**
3. **The policyholder fails to comply with participation or contribution rules;**
4. **The carrier elects to discontinue offering and non-renew all of its small group or large group plans delivered or issued for delivery in Colorado;**
5. **An employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan;**
6. **With respect to group health benefit plans offered through a managed care plan, there are no longer any enrollees who live, reside or work in the service area; or**
7. **With respect to coverage of an employer that is made available only through one or more bona fide associations, the membership of an employer ceases.**

Important Information for Employers with 50 or Fewer Employees and Business Groups of One: Rates are calculated based on allowable case characteristics – age bands, geographic location, family size, health status, and claims experience – and will be given within five working days of request. Rates for a specific employer cannot be adjusted due to the duration of coverage of employees or dependents of the small employer. Rates may change based on case characteristics, whenever benefits are changed, or upon giving written notice to the employer not less than 31 days prior to the effective date of the change. New applicants may be subject to pre-existing condition clauses, based on HIPAA requirements. Renewal of health insurance coverage in this class is guaranteed, assuming compliance with underwriting regulations. A Network Access Plan, which describes Anthem Blue Cross and Blue Shield's or HMO Colorado's network standards and evaluation procedures for ensuring provider access is available by calling our customer service department.

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS SPECIFIED BY LAW.

Cancer Screenings

At Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Colorado, Inc., we believe cancer screenings provide important preventive care that supports our mission: to improve the lives of the people we serve and the health of our communities. We cover cancer screenings as described below.

Pap Tests

All plans except our BeneFits plans provide coverage for an annual Pap test and the related office visit. Payment for the Pap test is based on the plan's provisions for laboratory or preventive care services, and payment for the related office visit is based on the plan's preventive care provisions. Under most plans pap tests received out of-network are not covered.

Mammogram Screenings

All plans except our HMO and PPO Basic Health Plans provide mammogram screening coverage for women. Frequency guidelines can be found in your certificate. Payment for the mammogram screening benefit is based on the plan's provisions for preventive care services. Our HMO and PPO Basic Health Plans do not provide coverage for mammogram screenings.

Prostate Cancer Screenings

All plans except our HMO and PPO Basic Health Plans provide prostate cancer screening coverage for men. Frequency guidelines can be found in your certificate. Payment for the prostate cancer screening benefit is based on the plan's provisions for preventive care services. Our HMO and PPO Basic Health Plans do not provide coverage for prostate cancer screenings.

Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All plans provide coverage for colorectal cancer screenings, such as colonoscopies, sigmoidoscopies and fecal occult blood tests. Depending on the type of colorectal cancer screening received, payment for the benefit is based on the plan's provisions for laboratory services, preventive care services, or other medical or surgical services. Our plans do not provide coverage for preventive colorectal cancer screenings involving invasive surgical procedures and DNA analysis. Under most plans colorectal cancer screenings received out of-network are not covered.

The information above is only a summary of the benefits described. The certificate for each health plan includes important additional information about limitations, exclusions and covered benefits. The Health Benefit Plan Description Form for each health plan includes additional information about copayments, deductibles and coinsurance. If you have any questions, please call our customer service department at the phone number on the Health Benefit Plan Description Form.