Anthem

Colorado Health Plan Description Form

Anthem Blue Cross and Blue Shield

Name of Carrier

BluePreferred PPO for Group
Option A 10/30/50/30%

Name of Plan

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 options reflect the amount the carrier will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. ANNUAL DEDUCTIBLE[2]		
a) Individual	No deductible	$500
b) Family	No deductible	$1,500 aggregate
5. OUT-OF-POCKET ANNUAL MAXIMUM[3]		
a) Individual	$1,000 excludes copayments	$3,000 excludes deductible and copayments
b) Family	$3,000 aggregate, excludes copayments	$9,000 aggregate, excludes deductible and copayments
c) Is deductible included in the out-of-pocket maximum?	No	No
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$2,000,000 per member in- and out-of-network combined for all covered services. Infertility services have a lifetime maximum payment by the carrier of $2,000 per member in- and out-of-network combined. Bariatric surgery has a lifetime maximum payment by the carrier of $7,500 per member for services received from a Center of Excellence facility or a lifetime maximum payment by the carrier of $1,500 per member for services received from a facility that has not been designated as a Center of Excellence; total lifetime maximum payment by the carrier shall not exceed $7,500 per member in- and out-of-network combined. Major organ transplants have a lifetime maximum payment by the carrier of $1,000,000 per transplant per member.	$2,000,000 per member in- and out-of-network combined for all covered services. Infertility services have a lifetime maximum payment by the carrier of $2,000 per member in- and out-of-network combined. Bariatric surgery has a lifetime maximum payment by the carrier of $1,500 per member for services received from a facility that has not been designated as a Center of Excellence; total lifetime maximum payment by the carrier shall not exceed $7,500 per member in- and out-of-network combined.

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	IN-NETWORK	OUT-OF-NETWORK
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. ROUTINE MEDICAL OFFICE VISITS[4]		
a) **Primary Care Providers**	$15 copayment per visit, for all other services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 90%. Excludes MRI, CT, PET scan, nuclear medicine and other high-tech services, see line 14.	Plan pays 70% after deductible
b) **Specialists**	$15 copayment per visit, for all other services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 90%. Excludes MRI, CT, PET scan, nuclear medicine and other high-tech services, see line 14.	Plan pays 70% after deductible
9. PREVENTIVE CARE		
a) **Children's services**	Up to age 13, $15 copayment per visit, for all other services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 90%, includes immunizations.	Up to age 13, plan pays 70%, not subject to deductible, includes immunizations.
b) **Adults' services**	$15 copayment per office visit, for all other services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 90%. In addition, mammogram screening and prostate screening are covered and are not subject to coinsurance. and are not subject to coinsurance.	Not covered except for mammogram screening and prostate screening, which are not subject to deductible or coinsurance.
10. MATERNITY		
a) **Prenatal care**	$200 copayment per pregnancy, for all other services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 90%.	Plan pays 70% after deductible
b) **Delivery & inpatient well baby care**[5]	Plan pays 90% after $250 copayment per admission	Plan pays 70% after $750 copayment per admission

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS **Level of coverage and restrictions on prescriptions**[6]		
a) Outpatient Pharmacy	Tier 1 generic formulary $10 copayment, tier 2 brand-name formulary $30 copayment, tier 3 non-formulary $50 copayment, tier 4 self-administered injectable drugs 30% copayment, per prescription at a participating pharmacy up to a 34-day supply.	Not covered
b) Prescription Mail Service	Tier 1 generic formulary $20 copayment, tier 2 brand-name formulary $60 copayment, tier 3 non-formulary $100 copayment, tier 4 self-administered injectable drugs 30% copayment, per prescription through the mail-order service up to a 90-day supply. For the tier 4 self-administered injectable prescription drugs, the maximum member copayment per prescription is $250 per 34-day supply at a participating pharmacy and a maximum member copayment of $500 per 90-day supply via mail-order service. Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem, up to $250 per member per calendar year, $500 per lifetime. In addition to the cost sharing described above, if you purchase a brand-name drug when there is a FDA rated equivalent generic drug available, you are responsible for the Tier-2 or Tier-3 Copayment for brand-name drugs and you will pay the difference between the cost of the brand-name and the cost of the generic. For example: a Tier-3 brand-name prescription costs $150; a generic Tier-1 substitution is available, the generic prescription costs $20, you pay the $130 difference plus the Tier-3 Copayment. The $130 difference is not applied towards any other cost-sharing requirement. For drugs on our approved list, call customer service at 877-833-5734. Covered only when received from a participating pharmacy.	Not covered
12. INPATIENT HOSPITAL	Plan pays 90% after $250 copayment per admission	Plan pays 70% after $750 copayment per admission
13. OUTPATIENT/AMBULATORY SURGERY	Plan pays 90% after $250 copayment per admission	Plan pays 70% after $750 copayment per admission
14. DIAGNOSTICS		
a) Laboratory & x-ray	Plan pays 90%	Plan pays 70% after deductible
b) MRI, nuclear medicine, and other high-tech services	Plan pays 90%	Plan pays 70% after deductible

	IN-NETWORK	OUT-OF-NETWORK
15. EMERGENCY CARE[7,8]	Plan pays 90% after $100 copayment per emergency room visit. Copayment is waived if admitted.	Plan pays 90% after deductible after $100 copayment per emergency room visit. Copayment is waived if admitted.
16. AMBULANCE		
a) Ground	Plan pays 100% after $200 copayment per trip	Plan pays 100% after $200 copayment per trip
b) Air	Plan pays 90% with a maximum benefit of $5,000 per trip	Plan pays 90%, not subject to deductible, with a maximum benefit of $5,000 per trip
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$15 copayment per visit, for all other services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 90%. Excludes MRI, CT, PET scan, nuclear medicine and other high-tech services, see line 14.	Plan pays 70% 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. 0THER MENTAL HEALTH CARE		
a) Inpatient care	Plan pays 50% after $250 copayment per admission. Limited to 45 full or 90 partial days per calendar year combined with Alcohol Abuse benefits (see line 20).	Not covered
b) Outpatient care	$15 copayment per visit. Limited to 30 visits with no less than $1,000 in payment by the carrier per calendar year.	Not covered
20. ALCOHOL & SUBSTANCE ABUSE		
a) Inpatient Care	**Alcohol abuse:** Plan pays 50% after $250 copayment per admission. Limited to 45 days per year or 90 partial days per calendar year combined with mental health benefits (see line 19). **Substance abuse:** Plan pays 50% after $250 copayment per admission. Limited to 30 days per calendar year or 60 days per lifetime.	Not covered
b) Outpatient care	Plan pays 50%. Limited to 20 visits with no less than $500 in payment by the carrier per calendar year for alcohol abuse; limited to 15 visits per calendar year for substance abuse.	Not covered
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY		
a) Inpatient	Plan pays 90% after $250 copayment per admission. Limited to 30 non-acute inpatient days per calendar year in- and out-of-network combined.	Plan pays 70% after $750 copayment per admission. Limited to 30 non-acute inpatient days per calendar year in- and out-of-network combined.
b) Outpatient	$15 copayment per visit, for all other services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 90%. Limited to 20 visits each for physical, occupational or speech therapy per calendar year in and out-of-network combined.	Plan pays 70% after deductible. Limited to 20 visits each for physical, occupational or speech therapy per calendar year in and out-of-network combined.

	IN-NETWORK	OUT-OF-NETWORK
22. DURABLE MEDICAL EQUIPMENT	Plan pays 90% with benefits limited to a maximum payment by the carrier of $3,000 per calendar year. The $3,000 maximum payment by the carrier 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 by the carrier 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.	Not covered
23. OXYGEN	Plan pays 90% with benefits limited to a maximum payment by the carrier of $3,000 per calendar year, combined with durable medical equipment (see line 22).	Not covered
24. ORGAN TRANSPLANTS	Plan pays 90% after $250 copayment per admission. Limited to a maximum total lifetime payment by the carrier of $1,000,000 per transplant. Transportation and lodging costs are limited to a maximum payment by the carrier of $10,000, donor costs are limited to a maximum payment by the carrier of $25,000. Transportation, lodging and donor costs are included in the maximum total lifetime payment per transplant.	Not covered
25. HOME HEALTH CARE	$15 copayment per visit, for all other services which are part of the visit (e.g., laboratory and x-ray services) plan pays 90%. Limited to 60 visits per calendar year.	Not covered
26. HOSPICE CARE	Plan pays 90%. Limited to 91 days per benefit period in-and out-of-network combined.	Plan pays 70% after deductible. Limited to 91 days per benefit period in-and out-of-network combined.
27. SKILLED NURSING FACILITY CARE	Plan pays 90% after $250 copayment per admission. Limited to 30 days per calendar year in- and out-of-network combined. Copayment is waived if admitted directly to a skilled nursing facility from an inpatient acute facility.	Plan pays 70% after $750 copayment per admission. Limited to 30 days per calendar year in- and out-of-network combined. Copayment is waived if admitted directly to a skilled nursing facility from an inpatient acute facility.
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Not covered	Not covered
30. CHIROPRACTIC CARE	$15 copayment per visit, for all other services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 90%. Limited to 12 visits per calendar year combined with acupuncture care (see line 31). .	Not covered

	IN-NETWORK	OUT-OF-NETWORK
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	**Acupuncture care:** $15 copayment per visit, for all other services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 90%. Limited to 12 visits per calendar year combined with chiropractic care (see line 30). **Second Opinion:** Members who desire another professional opinion, may obtain a second opinion.	Not covered **Second Opinion:** Members who desire another professional opinion, may obtain a second 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?	877-833-5734	877-833-5734
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 877-833-5734	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway Denver, CO 80273 877-833-5734
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	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 #'s 98887_Copay Group – Small Group Only	Policy form #'s 98887_Copay Group – Small Group Only
43. Does the plan have a binding arbitration clause?	Yes	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" 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) 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 may be noted in boxes 8 through 31.

[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 deductible 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 may be noted in boxes 8 through 31.

[4] Routine medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

[5] Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother 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 services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb threatening emergency existed.

[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.

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

Colorado law requires carriers to make available a Colorado Health 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.

Individual Health Plans

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 commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations;**
4. **The carrier elects to discontinue offering and non-renew all of its individual plans delivered or issued for delivery in Colorado.**

Group Health Plans

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, the availability of treatment for alcoholism, and the availability of hospice care. 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.**

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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.

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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 health of the people we serve. We cover cancer screenings as described below.

Pap Tests

All plans except our BasicBlue PPO Plan provide coverage for an annual Pap test and the related office visit. The BasicBlue PPO Plan provides coverage for a Pap test and the related office visit once every three years. Payment for the Pap test is based on the plan's laboratory services provisions, and payment for the related office visit is based on the plan's preventive care provisions. With our BluePreferred for Individuals PPO Plan, laboratory services for a Pap test are limited to a maximum payment of $75.00. With our Colorado HSA-Qualified Plans for Individuals, all services related to a Pap test are subject to the maximum benefit as described on the Health Plan Description Form. Under most plans pap tests received out of-network are not covered.

Mammogram Screenings

All plans except our HMO and PPO Basic Health and BluePreferred for Individual Plans provide mammogram screening coverage for women 35 years of age and older. For BluePreferred for Individuals the following frequency guidelines apply: For women between the ages of 35 years and 40 years, a single baseline screening mammogram is covered. For women between 40 years of age and less than 50 years of age, a screening mammogram is covered once every two years, or it is covered annually if the member's physician has determined that identified breast cancer risk factors are present. For women between the ages of 50 years and 65 years, a screening mammogram is covered annually. Payment for the mammogram screening benefit is based on the plan's provisions for X-ray 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 40 years of age and older. The following frequency guidelines apply: For men between 40 years of age and less than 50 years of age, a prostate cancer screening is covered annually if the member's physician has determined that identified prostate cancer risk factors are present. For men 50 years of age and older, a prostate cancer screening is covered annually. Payment for the prostate cancer screening benefit is based on the plan's provisions for X-ray 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 except BluePreferred for Individual 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 office visit 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 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 Plan Description Form.

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