

**Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield**

Name of Carrier
PPO \$30 Copay \$3000D
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 covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. Deductible Type²	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE^{2a}		
a) Individual^{2b}	\$3,000, excludes copayments	\$6,000
b) Family^{2c}	\$6,000 aggregate, excludes copayments	\$12,000 aggregate
5. OUT-OF-POCKET ANNUAL MAXIMUM³		
a) Individual	\$5,000 excludes deductible and copayments	\$10,000 excludes deductible
b) Family	\$10,000 aggregate, excludes deductible and copayments	\$20,000 aggregate, excludes deductible
c) Is deductible included in the out-of-pocket maximum?	No	No
	Some covered services have a maximum numbers of days, visits or dollar amounts allowed during a calendar year. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied.	Some covered services have a maximum numbers of days, visits or dollar amounts allowed during a calendar year. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied.

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Si usted necesita ayuda en español para entender este 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 in- and out-of-network combined for all covered services. 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 Center of Excellence facility or a lifetime maximum benefit of \$1,500 per member for services received from a facility that has not been designated as a Center of Excellence; total lifetime maximum benefit shall not exceed \$7,500 per member in- and out-of-network combined.	\$6,000,000 per member in- and out-of-network combined for all covered services. 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 has not been designated as a Center of Excellence; total lifetime maximum benefit 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 VISITS⁴		
a) Primary Care Providers	\$30 copayment per visit; no coinsurance (100% covered) for all other services which are performed in the physician's office and billed by the physician (e.g., laboratory and x-ray services). Services performed or billed by another provider are not included in the visit copayment, see line 14 for payment information. Excludes MRI, CT, PET scans, nuclear medicine and other high-tech services, see line 14.	50% coinsurance after deductible
b) Specialists	\$30 copayment per visit; no coinsurance (100% covered) for all other services which are performed in the physician's office and billed by the physician (e.g., laboratory and x-ray services). Services performed or billed by another provider are not included in the visit copayment, see line 14 for payment information. Excludes MRI, CT, PET scans, nuclear medicine and other high-tech services, see line 14.	50% coinsurance after deductible

	IN-NETWORK	OUT-OF-NETWORK
9. PREVENTIVE CARE a) Children's services b) Adults' services	<p>Up to age 13, \$30 copayment per visit. Copayment includes services provided as preventive care.</p> <p>\$30 copayment per office visit. Copayment includes services provided as preventive care.</p> <p>Includes coverage for preventive colon cancer</p>	<p>Up to age 13, 50% coinsurance, not subject to deductible.</p> <p>Not covered except for mammogram screening and prostate screening, which are not subject to deductible or coinsurance and preventive colorectal cancer screening which is not subject to deductible, but is subject to coinsurance.</p>
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care⁵	<p>\$30 copayment for first prenatal care office visit/delivery from the physician; no coinsurance (100% covered) for all other services which are performed in the physician's office and billed by the physician (e.g., laboratory and x-ray services). Services performed or billed by another provider are not included in the visit copayment, see line 14 for payment information.</p> <p>20% coinsurance after deductible for facility services</p>	<p>50% coinsurance after deductible</p> <p>50% coinsurance after deductible</p>

	IN-NETWORK	OUT-OF-NETWORK
<p>11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions⁶</p> <p>a) Inpatient care</p> <p>b) Outpatient Pharmacy</p> <p>c) Prescription Mail Service</p>	<p>Included with the inpatient hospital benefit (see line 12)</p> <p>Retail Pharmacy Drugs - Tier 1 \$15 copayment, tier 2 \$30 copayment, tier 3 \$50 copayment, tier 4 30% copayment, per prescription at a participating pharmacy up to a 30-day supply. For tier 4 retail pharmacy drugs, the maximum copayment per prescription is \$250 per 30-day supply.</p> <p>Specialty Pharmacy Drugs - Tier 1 \$15 copayment, tier 2 \$30 copayment, tier 3 \$50 copayment, tier 4 30% copayment, per prescription from our Specialty Pharmacy up to a 30-day supply. For tier 4 Specialty Pharmacy Drugs the maximum copayment per prescription is \$250 per 30-day supply from our Specialty Pharmacy. Specialty Pharmacy Drugs are not available at a retail pharmacy or from a mail-order pharmacy.</p> <p>Mail-Order Pharmacy Drugs - Tier 1 \$15 copayment, tier 2 \$60 copayment, tier 3 \$100 copayment, tier 4 30% copayment, per prescription through the mail-order service up to a 90-day supply. For the tier 4 mail-order drugs, the maximum copayment per prescription is \$250 per 30-day supply or \$500 per 90-day supply. Specialty pharmacy drugs are not available through the mail-order service.</p> <p>The following applies to b) and c) above: Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem, up a \$500 per lifetime maximum benefit.</p> <p>Prescription Drugs will always be dispensed as ordered by your provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket expenses. You may request, or your provider may order, the brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and brand-name drug, in addition to your tier 1 copayment. By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness. Anthem reserves the right, at our discretion, to remove certain higher cost generic drugs from this policy. For drugs on our approved list, call customer service at 877-833-5734.</p>	<p>Included with inpatient hospital benefit (see line 12)</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

	IN-NETWORK	OUT-OF-NETWORK
12. INPATIENT HOSPITAL	20% coinsurance after deductible	50% coinsurance after deductible
13. OUTPATIENT/AMBULATORY SURGERY	20% coinsurance after deductible	50% coinsurance after deductible
14. DIAGNOSTICS		
a) Laboratory & x-ray	20% coinsurance after deductible for laboratory or x-ray services which are not included in the applicable visit copayment or that were billed on a different date than the office visit.	50% coinsurance after deductible
b) MRI, nuclear medicine, and other high-tech services	20% coinsurance after deductible	50% coinsurance after deductible
15. EMERGENCY CARE^{7,8}	20% coinsurance after deductible	20% coinsurance after deductible
16. AMBULANCE		
a) Ground	20% coinsurance after deductible	20% coinsurance after deductible
b) Air	20% coinsurance after deductible	20% coinsurance after deductible
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	\$30 copayment per visit; no coinsurance (100% covered) for all other services which are performed in the physician's office and billed by the physician (e.g., laboratory and x-ray services). Services performed or billed by another provider are not included in the visit copayment, see line 14 for payment information. Excludes MRI, CT, PET scans, nuclear medicine and other high-tech services, see line 14.	50% coinsurance after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹	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	20% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law.	50% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law.
b) Outpatient care	Up to \$30 copayment per office visit, subject to any applicable cost-share maximums imposed by law.	50% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law.
20. ALCOHOL & SUBSTANCE ABUSE		
a) Inpatient Care	20% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law.	50% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law.
b) Outpatient care	Up to \$30 copayment per office visit, subject to any applicable cost-share maximums imposed by law.	50% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law.

	IN-NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY a) Inpatient b) Outpatient	<p>20% coinsurance after deductible. Covered for inpatient rehabilitation therapy for up to 30 non-acute inpatient days per calendar year in- and out-of-network combined.</p> <p>20% coinsurance after deductible. Limited to 20 visits each for physical, occupational or speech therapy per calendar year in and out-of-network combined, from birth until the third birthday benefits are provided as required by applicable law..</p>	<p>50% coinsurance after deductible. Covered for inpatient rehabilitation therapy for up d to 30 non-acute inpatient days per calendar year in- and out-of-network combined.</p> <p>50% coinsurance after deductible. Limited to 20 visits each for physical, occupational or speech therapy per calendar year in and out-of-network combined, from birth until the third birthday benefits are provided as required by applicable law..</p>
22. DURABLE MEDICAL EQUIPMENT	20% coinsurance after deductible with benefits limited to a maximum benefit of \$3,000 per calendar year. The \$3,000 maximum benefit 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 benefit of \$3,000	Not covered
23. OXYGEN	20% coinsurance after deductible with benefits limited to a maximum benefit of \$3,000 per calendar year, combined with durable medical equipment (see line 22).	Not covered
24. ORGAN TRANSPLANTS a) Inpatient b) Outpatient	<p>20% coinsurance after deductible</p> <p>\$30 copayment per visit; no coinsurance (100% covered) for all other services which are performed in the physician's office and billed by the physician (e.g., laboratory and x-ray services). Services performed or billed by another provider are not included in the visit copayment, see line 14 for payment information. Excludes MRI, CT, PET scans, nuclear medicine and other high-tech services, see line 14.</p> <p>Transportation and lodging services are limited to a maximum benefit of \$10,000; unrelated donor searches are limited to a maximum benefit of \$30,000.</p>	<p>Not covered</p> <p>Not covered</p>
25. HOME HEALTH CARE	20% coinsurance after deductible. Limited to 100 visits per calendar year.	Not covered
26. HOSPICE CARE	20% coinsurance after deductible	50% coinsurance after deductible
27. SKILLED NURSING FACILITY CARE	20% coinsurance after deductible. Limited to 100 days per calendar year in- and out-of-network combined.	50% 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

	IN-NETWORK	OUT-OF-NETWORK
30. CHIROPRACTIC CARE	\$20 copayment per visit, no coinsurance (100% covered) for all other services which are performed in the chiropractor's office and billed by the chiropractor (e.g., laboratory and x-ray services). Services performed or billed by another provider are not included in the visit copayment, see line 14 for payment information. Limited to 20 visits per calendar year combined with massage therapy and acupuncture care.	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	<p>Massage Therapy \$20 copayment per visit, no coinsurance (100% covered) for all other services which are performed in the massage therapists office and billed by the massage therapists (e.g., laboratory and x-ray services). Services performed or billed by another provider are not included in the visit copayment, see line 14 for payment information. Limited to 20 visits per calendar year combined with chiropractic care and acupuncture care.</p> <p>Acupuncture care: \$20 copayment per visit, no coinsurance (100% covered) for all other services which are performed in the acupuncturist's office and billed by the acupuncturist (e.g., laboratory and x-ray services). Services performed or billed by another provider are not included in the visit copayment, see line 14 for payment information. Limited to 20 visits per calendar year combined with massage therapy and chiropractic care.</p> <p>Nutritional Therapy \$20 copayment per visit for specialist. Limited to 4 visits per calendar year.</p> <p>Hearing Aids Benefit level determined by place of service. Hearing aids are covered up to age 18 and are supplied every 5 years, except as required by law.</p> <p>Second Opinion: Members who desire another professional opinion may obtain a second opinion.</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Hearing Aids Benefit level determined by place of service. Hearing aids are covered up to age 18 and are supplied every 5 years, except as required by law.</p> <p>Second Opinion: Members who desire another professional opinion may obtain a second opinion.</p>

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. ¹⁰	6 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 2986_Copay Group – Small Group Only	Policy form #'s 2986_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 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.

