

## Colorado Health Benefit Plan Description Form Anthem Blue Cross and Blue Shield Preferred Provider Basic Limited Mandate Health Benefit Plan for Colorado

### PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider organization plan (PPO)
2. OUT-OF-NETWORK CARE COVERED? <sup>1</sup>	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 <sup>2</sup>	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE <sup>2a</sup>		Deductibles are separate from in-network deductibles.
a) Individual <sup>2b</sup>	\$4,000	\$8,000
b) Family <sup>2c</sup>	\$12,000	\$24,000
5. OUT-OF-POCKET ANNUAL MAXIMUM <sup>3</sup>		Out-of-pocket amounts are separate from in-network out-of-pocket amounts.
a) Individual	\$10,000, excluding flat dollar copayments	\$16,000
b) Family	\$20,000, excluding flat dollar copayments	\$32,000
c) Is deductible included in the out-of-pocket maximum?	Yes	Yes
5A. COINSURANCE or COPAYMENT	30% coinsurance	50% coinsurance
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$5 million	
7A. COVERED PROVIDERS	PPO provider network. See the 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?	Not applicable. This is not a network plan.	

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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
8. MEDICAL OFFICE VISITS <sup>4</sup> a) Primary Care Providers b) Specialists	\$40 copayment per visit \$60 copayment per visit	50% coinsurance after deductible 50% coinsurance after deductible
9. PREVENTIVE CARE  a) Children's services (No deductible)  b) Adults' services  c) Colorectal screening services  d) Mandated Preventive Services	Only specified preventive services are covered. Prostate cancer screenings are not covered. The coverage requirements mandated by §10-16-104(18), C.R.S., do apply to the Basic Limited Mandate Health Benefit Plans.  \$40 copayment per visit  \$40 copayment per visit  \$40 copayment per visit \$500 copay for outpatient/ambulatory surgery procedures (no deductible)  Coverage shall be provided for asymptomatic, average risk adults who are 50 to 75 years of age and all covered persons who are at high risk for colorectal cancer, including covered persons who have a family medical history of colorectal cancer; a prior occurrence of cancer or precursor neoplastic polyps; a prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or other predisposing factors as determined by the provider.  \$40 copayment per visit (no deductible)  Effective January 1, 2010, coverage includes all preventive services as mandated by §10-16-104(18), C.R.S. in accordance with "A" and "B" recommendations of the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services. See the certificate for a list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Insurance Bulletin B-4.24. For the basic HMO plan, services are covered only if they are rendered by a provider who is designated by and affiliated with the HMO.	50% coinsurance after deductible  50% coinsurance after deductible
10. MATERNITY <sup>5</sup>	30% coinsurance  Applicable copayments, deductibles and coinsurance apply to each type of service.	50% coinsurance after deductible
11. PRESCRIPTION DRUGS <sup>6</sup> Level of coverage and restrictions on prescriptions a) Outpatient care  b) Prescription Mail Service	\$150 separate annual deductible per person  Copayment per prescription, up to a 34-day supply: \$20 for tier 1 generic formulary; \$50 for tier 2 brand formulary; \$70 for tier 3 non-formulary  Copayment per prescription, up to a 90-day supply: \$40 for tier 1 generic formulary; \$100 for tier 2 brand formulary; \$140 for tier 3 non-formulary  For drugs on Anthem's formulary, visit <a href="http://www.Anthem.com">www.Anthem.com</a> or contact Anthem's customer service department (see line 39 for phone number).	Copayment per prescription, up to a 34-day supply: \$20 for tier 1 generic formulary; \$50 for tier 2 brand formulary; \$70 for tier 3 non-formulary  Copayment per prescription, up to a 90-day supply: \$40 for tier 1 generic formulary; \$100 for tier 2 brand formulary; \$140 for tier 3 non-formulary  For drugs on Anthem's formulary, visit <a href="http://www.Anthem.com">www.Anthem.com</a> or contact Anthem's customer service department (see line 39 for phone number).
12. INPATIENT HOSPITAL	30% coinsurance after deductible	50% coinsurance after deductible
13. OUTPATIENT/AMBULATORY SURGERY	30% coinsurance after deductible	50% coinsurance after deductible

	IN-NETWORK	OUT-OF-NETWORK
14. DIAGNOSTICS a) Laboratory & X-ray	30% coinsurance after deductible.	50% coinsurance after deductible
b) MRI, Nuclear Medicine, CT, CTA, MRA, and PET scans	30% coinsurance after deductible	50% coinsurance after deductible
15. EMERGENCY CARE <sup>7,8</sup>	\$250 copayment per visit, then 30% coinsurance (no deductible)	
16. AMBULANCE	30% coinsurance after deductible	30% coinsurance after in-network deductible
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	\$100 copayment per visit	50% coinsurance after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE <sup>9</sup>	Coverage is no less extensive than the coverage provided for any other physical illness.	
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	Excluded Excluded	
20. ALCOHOL & SUBSTANCE ABUSE	Excluded	
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY	30% coinsurance after deductible. Limited to 25 visits per therapy per year, in- and out-of-network combined.  The 25-visit limitation is not applied to children under 6 years of age. Benefits for children under 6 years of age are covered as provided by law.  Coverage for medically necessary therapeutic treatment only; benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age.	50% coinsurance after deductible. Limited to 25 l visits per therapy per year in and out-of-network combined.
22. DURABLE MEDICAL EQUIPMENT	30% coinsurance after deductible	50% coinsurance after deductible.  \$1,500 maximum per year. In-network deductible applies to network providers and the out-of-network deductible applies to out-of-network providers. However, the maximum benefit is combined for in- and out-of-network benefits. The \$1,500 maximum Anthem 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.  Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen and reusable equipment for the treatment of diabetes. The cost of prosthetics does not apply to the annual DME maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by §10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered, but repair and replacement needed due to misuse/abuse by the insured is <i>not</i> covered.
23. OXYGEN	Included under durable medical equipment (line 22)	Included under durable medical equipment (line 22)
24. ORGAN TRANSPLANTS	Covered transplants include liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, and bone marrow for Hodgkin's disease, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high-risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions listed above for bone marrow transplants.  30% coinsurance after deductible	
25. HOME HEALTH CARE	30% coinsurance after deductible	50% coinsurance after deductible

	IN-NETWORK	OUT-OF-NETWORK
	Limited to 60 visits per year combined maximum	
26. HOSPICE CARE	30% coinsurance after deductible	50% coinsurance after deductible
27. SKILLED NURSING FACILITY CARE	30% coinsurance after deductible (not to exceed 100 days per calendar year)	50% coinsurance after deductible (not to exceed 100 days per calendar year)
28. DENTAL CARE	Not covered except for dental care needed as a result of an accident.	
29. VISION CARE	Excluded	
30. CHIROPRACTIC CARE	Excluded	
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)  a) Hearing Aids	<p>Benefit level determined by place of service.</p> <p>Hearing aids for dependent children under the age of 18 are covered. The coverage includes the initial assessment, fitting, adjustments, and the required auditory training. Initial hearing aids and replacement hearing aids are not covered more frequently than every five (5) years; however, a new hearing aid is covered when alterations to the existing hearing aid cannot adequately meet the needs of the child. Hearing aids are not considered to be durable medical equipment. Benefits shall be provided in the same manner as the same types of services for other covered conditions and are determined by where the hearing aid is accessed (i.e. an office visit copay will apply if the hearing aid is provided as part of an office visit). Hearing aids are subject to utilization review.</p>	

**PART C: LIMITATIONS AND EXCLUSIONS**

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. <sup>10</sup>	Business groups of one: Up to 12 months for all pre-existing conditions. Business groups of two-50: Up to six 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 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?	Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents and anesthesia for dependent children as required by law; educational training problems; experimental and investigational procedures; eye glasses and contact lenses; hearing aids and fitting (see line 31); learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illness and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.

**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	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes
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	
40. Whom do I write/call if I have a complaint or want to file a grievance? <sup>11</sup>	Anthem Blue Cross and Blue Shield P.O. Box 17549 Denver, CO 80217-0549 See line 39 for phone numbers	
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 # 95981 Group – small	
43. Does the plan have a binding arbitration clause?	Yes	

<sup>1</sup> “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).

<sup>2</sup> “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.”

<sup>2a</sup> “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.

<sup>2b</sup> “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.

<sup>2c</sup> “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., “\$3,000 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.

<sup>3</sup> “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.

<sup>4</sup> Medical office visits include physician, mid-level practitioner, and specialist visits.

<sup>5</sup> 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 no separate copayments.

<sup>6</sup> Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

<sup>7</sup> “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.

<sup>8</sup> 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.

<sup>9</sup> "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

<sup>10</sup> 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.

<sup>11</sup> 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 and 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.

For those enrolled on a health benefit plan other than the Colorado Basic Limited Mandate Health Benefit Plan:

Small employers purchasing any health benefit plan other than the Colorado Basic Limited Mandate Health Benefit Plan must pay for all of the mandated benefits pursuant to section 10-16-104, C.R.S. The premium for this plan includes the cost of these mandated benefits, specifically: 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, hospitalization and general anesthesia for dental procedures for dependent children, diabetes, prosthetic devices, early intervention services for certain children, colorectal screening, cervical cancer vaccinations, and certain routine care during participation in a clinical trial.

For those enrolled on the Colorado Basic Limited Mandate Health Benefit Plan:

Interested policyholders, certificate holders, and enrollees are hereby given notice that this small group policy does not cover all the health services and benefits, including prostate screenings, mental health, alcoholism, and dental anesthesia for children, which the Colorado Revised Statutes usually require group plans to cover.

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 provide coverage under the preventive care benefits for a routine annual Pap test and the related office visit. Payment for the routine Pap test is based on the plan's provisions for preventive care service. Payment for the related office visit is based on the plan's preventive care provisions.

### Mammogram Screenings

All plans provide coverage under the preventive care benefits for one routine screening or diagnostic mammogram per year regardless of age (or in accordance with the frequency determined by your provider) for women. Payment for the mammogram screening benefit is based on the plan's provisions for preventive care and is normally not subject to the deductible or coinsurance.

### Prostate Cancer Screenings

All plans except our HMO and PPO Basic Health Plans provide coverage under the preventive care benefits for one routine prostate cancer screening per year regardless of age (or in accordance with the frequency determined by your provider) for men. Payment for the prostate cancer screening is based on the plan's provisions for preventive exam and laboratory services and is normally not subject to the deductible or coinsurance.

### Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All plans provide coverage for routine colorectal cancer screenings, such as fecal occult blood tests, barium enema, sigmoidoscopies and colonoscopies. Depending on the type of colorectal cancer screening received, payment for the benefit is based on where the services are rendered and if rendered as a screening or medical procedure. Colorectal cancer screenings are covered under preventive care as long as the services provided are for a preventive screening. Payment for preventive colorectal cancer screenings are not subject to the deductible or coinsurance.

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 Colorado 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 Colorado Health Benefit Plan Description Form.