Anthem
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Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
Colorado Individual ClearProtection 1,000; 3,300; 5,000 Plan
Effective January 1, 2011

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	Calendar Year
4a. ANNUAL DEDUCTIBLE[2a] **Inpatient Surgical/Hospital Deductible**	**Not combined for In-Network and Out-of-Network** Applicable only to the following services: ○ All inpatient services ○ Ambulatory Surgery Center Services ○ Emergency Room Visits ○ Home Health Care ○ Skilled Nursing Care ○ Hospice Services ○ Ambulance Services	
a) Individual[2b]	$1,000; 3,300; 5,000 per individual During each Year, each member is responsible for all Surgical/Hospital expenses incurred up to the Surgical/Hospital Deductible amount. Once you have satisfied your Surgical/Hospital Deductible, no further Surgical/Hospital Deductible will be required for the remainder of that Year.	$ 1,000; 3,300; 5,000 per individual During each Year, each member is responsible for all Surgical/Hospital expenses incurred up to the Surgical/Hospital Deductible amount. Once you have satisfied your Surgical/Hospital Deductible, no further Surgical/Hospital Deductible will be required for the remainder of that Year.

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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
b) Family[2c]	$2,000; 6,600; 10,000 maximum per family During each year, each member is responsible for all Surgical/Hospital expenses incurred up to the Surgical/Hospital deductible amount. Once you have satisfied your In-Network Surgical/Hospital deductible, no further Surgical/Hospital deductible will be required for the remainder of that year. Once the total of allowable charges applying to the Surgical/Hospital Deductible for two (2) or more Insureds equal the Surgical/Hospital Deductible Family Maximum, no further Surgical/Hospital Deductible will be required for all enrolled Insureds for the remainder of that Year. No one Insured can contribute more than the individual deductible amount to the family deductible amount.	$ 2,000; 6,600; 10,000 maximum per family During each year, each member is responsible for all Surgical/Hospital expenses incurred up to the Surgical/Hospital deductible amount. Once you have satisfied your Out-of-Network Surgical/Hospital deductible, no further Surgical/Hospital deductible will be required for the remainder of that year. Once the total of allowable charges applying to the Surgical/Hospital Deductible for two (2) or more Insureds equal the Surgical/Hospital Deductible Family Maximum, no further Surgical/Hospital Deductible will be required for all enrolled Insureds for the remainder of that Year. No one Insured can contribute more than the individual deductible amount to the family deductible amount. For Non-Participating providers, the member must pay the difference between Anthem's maximum allowed amount and the non-participating provider's billed charges, unless noted otherwise. Charges in excess of the maximum allowed amount do not count towards satisfying the Inpatient Surgical/Medical Deductible. Please see the section of your certificate entitled About Your Health Coverage for details about cost sharing requirements.
Outpatient Professional Services Deductible	**Not combined for In-Network and Out-of-Network** Applicable only to the following services: ○ Professional Services ○ Outpatient Services ○ Physical Therapy ○ Occupational Therapy ○ Speech Therapy	
a) Individual[2b]	$4,500; 6,800; 8,500 per Individual During each Year, each member is responsible for all Outpatient Professional expenses incurred up to the Outpatient Professional Services Deductible amount. Once you have satisfied your In Network and/or Out-of-Network Provider Outpatient Professional Services Deductible, no further Outpatient Professional Services Deductible will be required for the remainder of that Year.	$4,500; 6,800; 8,500 per Individual During each Year, each member is responsible for all Outpatient Professional expenses incurred up to the Outpatient Professional Services Deductible amount. Once you have satisfied your In Network and/or Out-of-Network Provider Outpatient Professional Services Deductible, no further Outpatient Professional Services Deductible will be required for the remainder of that Year.

	IN-NETWORK	OUT-OF-NETWORK
b) Family[2c]	$9,000; 13,600; 17,000 maximum per family Once the total of allowable charges applying to the Outpatient Professional Services Deductible for two (2) or more members equal the Outpatient Professional Services Deductible Family Maximum, no further Outpatient Professional Services Deductible will be required for all enrolled members for the remainder of that Year. No one member can contribute more than the individual deductible amount to the family deductible amount	$9,000; 13,600; 17,000 maximum per family Once the total of allowable charges applying to the Outpatient Professional Services Deductible for two (2) or more members equal the Outpatient Professional Services Deductible Family Maximum, no further Outpatient Professional Services Deductible will be required for all enrolled members for the remainder of that Year. No one member can contribute more than the individual deductible amount to the family deductible amount. For Non-Participating providers, the member must pay the difference between Anthem's maximum allowed amount and the non-participating provider's billed charges, unless noted otherwise. Charges in excess of the maximum allowed amount do not count towards satisfying the Outpatient Professional Services Deductible. Please see the section of your certificate entitled About Your Health Coverage for details about cost sharing requirements.
	Note: The first two (2) office visits from In-Network Providers are covered at a $40 copay per member, per calendar year regardless of the type of provider seen. The Outpatient Professional Services Deductible is waived, but the $40 office visit copayment will not be applied towards the In-network Out-of-Pocket Annual maximum. Copayment amounts do not apply to either the Inpatient Surgical/Hospital Deductible or the Outpatient Professional Services Deductible.	

	IN-NETWORK	OUT-OF-NETWORK
5. OUT-OF-POCKET ANNUAL MAXIMUM	The Out-of-Pocket Annual Maximum includes the deductibles, but is **not** combined for In and Out-of-Network.	
a) Individual[3]	$4,500; 6,800; 8,500 per individual, includes deductible and coinsurance.	$4,500; 6,800; 8,500 per individual, includes deductible and coinsurance.
b) Family	$9,000; 13,600; 17,000 per family, includes deductible and coinsurance.	$9,000; 13,600; 17,000 per family, includes deductible and coinsurance.
	Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual out-of-pocket annual maximum, combine to equal the family out-of-pocket annual maximum, no member will be required to pay Surgical/Hospital Deductible amounts, Yearly Outpatient Professional Services Deductible amount or Copayment/Coinsurance amounts, except as otherwise required by this policy for the remainder of that year. However, no one person can contribute more than their individual out-of-pocket annual maximum amount to the family out-of-pocket annual maximum.	Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual out-of-pocket annual maximum, combine to equal the family out-of-pocket annual maximum, member will be required to pay Surgical/Hospital Deductible amounts, Yearly Outpatient Professional Services Deductible amount or Copayment/Coinsurance amounts, except as otherwise required by this policy for the remainder of that year, **except** for charges in excess of the maximum allowed amount and where specifically noted in the certificate. However, no one person can contribute more than their individual out-of-pocket annual maximum amount to the family out-of-pocket annual maximum. A member will always be responsible for the difference between billed charges and the maximum allowed amount for non-participating providers, even after reaching the Out-of-Pocket Annual Maximum for Out-of-Network services. Charges in excess of the maximum allowed amount do not count towards satisfying the Out-of-Pocket Annual Maximum.
c) Is the deductible included in the out-of-pocket maximum?	Yes	Yes
	Copayments amounts do not apply to the Out-of-Pocket Annual Maximum. Prescription drug expenses do not apply towards this Out of Pocket maximum and will accumulate towards separate maximums as indicated in # 11 Prescription Drugs.	
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime limits. For benefit limits please see each applicable benefit below.	
7A. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list or 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

	IN-NETWORK	OUT-OF-NETWORK
8. MEDICAL OFFICE VISITS[4] Subject to the Outpatient Professional Services Deductible	$40 copayment per office visit for the first two (2) office visits in a calendar year.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.
a) Primary Care Providers	After the first two (2) office visits in a calendar year have been used, the member pays 100% of the allowed amount until the Outpatient Professional Services Deductible has been satisfied, then 0% coinsurance	
b) Specialists	$40 copayment per office visit for the first two (2) office visits in calendar year. After the first two (2) office visits in a calendar year have been used, the member pays 100% of the allowed amount until the Outpatient Professional Services Deductible has been satisfied, then 0% coinsurance	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.
	The first two (2) office visits from In-Network Providers are covered at a $40 copay per member, per calendar year regardless of the type of provider seen. The total number of visits covered at the $40 copay is combined for all In-Network Providers. No Outpatient Professional Services Deductible is required for the first two (2) office visits from In-Network Providers. Services covered as part of an office visit include: ○ History (gathering of information on an illness or injury) ○ Examination ○ Medical decision making (the physician's actual diagnosis and treatment plan) All other covered professional services, including, but not limited to laboratory, X-ray, radiology and pathology services are subject to applicable deductible, coinsurance, or cost sharing. Please see the Professional Services section of the certificate for a full description of covered professional services. After the first two (2) In-Network physician office visits have been used, charges for additional physician office visits will be subject to the Outpatient Professional Services Deductible and Out-of-Pocket Annual Maximum. Copayment amounts do not apply to the deductible or the out of pocket maximum.	

	IN-NETWORK	OUT-OF-NETWORK
9. PREVENTIVE CARE **a) Children's services**	Preventive Care Services shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the covered member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below: 1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: • Breast cancer; • Cervical cancer; • Colorectal cancer; • High Blood Pressure; • Type 2 Diabetes Mellitus; • Cholesterol; • Child and Adult Obesity. 2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and 4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.	$40 copay, not subject to the Outpatient Professional Services Deductible for: Early intervention services, preventive services and immunizations (including the cervical cancer vaccination) pursuant to the schedule established by the Advisory Committee on Immunization Practices. Child health supervision services shall be provided up to age 13. Child health supervision services shall be exempt from a deductible or dollar limit provision. Copayments and coinsurance may be imposed for child health supervision services, but they shall not exceed the copayment or coinsurance payment, as applicable, to a physician visit. All other preventive care services (not mandated by Colorado law) are not covered.

	IN-NETWORK	OUT-OF-NETWORK
b) Adults' services	Preventive Care Services shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the covered member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below: 1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: • Breast cancer; • Cervical cancer; • Colorectal cancer; • High Blood Pressure; • Type 2 Diabetes Mellitus; • Cholesterol; • Child and Adult Obesity. 2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and 4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.	$40 copay, not subject to the Outpatient Professional Services Deductible for: Routine cytological screening (pap test), mammography benefit in accordance to Colorado law, colorectal cancer examination and related laboratory tests, cholesterol screening, immunizations against cervical cancer, influenza and pneumococcal vaccinations, alcohol misuse and tobacco use screening and behavioral counseling or cessation interventions, and prostate cancer screening. All other preventive care services (not mandated by Colorado law) are not covered.
	Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services. Copayment amounts paid to out of network providers do not apply to the Inpatient Surgical/Hospital Deductible, the Outpatient Professional Services Deductible or the Out of Pocket annual maximum.	
10. MATERNITY **Outpatient Services are subject to the Outpatient Professional Services Deductible** **Inpatient Services are subject to the Inpatient Surgical/Hospital Deductible** **a) Prenatal care** **(outpaitient services)**	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied 50% coinsurance plus all charges in excess of the maximum allowed amount.
(inpatient services)	After the Inpatient Surgical/Hospital Deductible has been satisfied 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied 50% coinsurance plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
b) Delivery & inpatient well baby care[5]	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions** **a) Outpatient care**	**Retail Pharmacy:** **Tier 1 Prescription Drugs:** ○ $15 copayment for each prescription and/or refill for a maximum thirty (30) day supply. **Tier 2 Prescription Drugs:** After the $7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied: ○ $40 copayment for each prescription and/or refill for a maximum thirty (30) day supply. **Tier 3 Prescription Drugs:** After the $7500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied: ○ $60 copayment for each prescription and/or refill for a maximum thirty (30) day supply. **Tier 3 Specialty Prescription Drugs*:** After the $7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied: ○ 25% coinsurance for each prescription and/or refill for a maximum thirty (30) day supply. ***Specialty Pharmacy Drugs:** Specialty drugs are high-cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty drugs may have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance.	Not covered

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions (continued)** **b) Prescription Mail Service**	**Mail Order:** ○ **Tier 1 Prescription Drugs:** $45 copayment for each prescription and/or refill up to a maximum ninety (90) day supply. **Tier 2 Prescription Drugs:** After a $7,500 per member per calendar year Tier 2 and Tier 3 Prescription Drug Deductible is satisfied: ○ $120 copayment for each prescription and/or refill up to a maximum ninety (90) day supply. **Tier 3 Prescription Drugs:** After a $7,500 per member per calendar year Tier 2 and Tier 3 Prescription Drug Deductible is satisfied: ○ $180 copayment for each prescription and/or refill up to a maximum ninety (90) day supply.	Not covered
	Tier 2 and Tier 3 Prescription Drug Deductible Each member must meet a Tier 2 and Tier 3 Prescription Drug Deductible amount of $7500 each Year. This Deductible is separate from the annual Deductibles for medical benefits and does not accumulate towards satisfying the medical In-Network or Out-of-Network Provider Deductibles. This Tier 2 and Tier 3 Prescription Drug Deductible applies to Tier 2 and Tier 3 Prescription Drugs purchased at Participating Pharmacies and through the Mail Order Prescription Drug Program. **Note:** • Copayments for the Tier 2 and Tier 3 deductible **will not** accumulate towards the Tier 3 Specialty Prescription Drug Coinsurance Maximum and will continue to be required even after the Tier 3 Specialty Prescription Drug Coinsurance Maximum has been reached. • The Tier 2 and Tier 3 Drug Deductible **will not** accumulate to satisfy the Tier 3 Specialty Prescription Drug Coinsurance Maximum. **Tier 3 Specialty Prescription Drug Out of Pocket Maximum** There is a $2500 Tier 3 Specialty Prescription Drug Out-of-Pocket maximum per member per calendar year when purchased from a preferred specialty pharmacy. You will not be required to pay more than $2500 per member per calendar year for prescription drugs purchased at a preferred specialty pharmacy. Once the Tier 3 Specialty Prescription Drug Out of Pocket Maximum is met, no further Coinsurance will be required for drugs purchased from a preferred special pharmacy for the remainder of that calendar year. Copayments for Tier 1 and Tier 2 drugs will not accumulate towards the Tier 3 Specialty Prescription Drug Out of Pocket Maximum, and will continue to be required even after the Tier 3 Specialty Prescription Drug Out of Pocket Maximum has been reached. Prescription drug expenses do not apply towards the Out of Pocket maximum for medical benefits and will accumulate towards the separate maximums indicated above. Note: Specialty drugs are only available through Anthem's specialty pharmacy benefit manager. Drugs obtained from pharmacies outside the United States will not be covered unless such drugs are prescribed in connection with Emergency	

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions (continued)**	**Non-Formulary Prescription Drugs:** Charges for non-formulary prescription drugs will not be applied towards the Prescription Drug Deductible or the Tier 2 and Tier 3 Out-of-Pocket Maximum. • 100% of the contracted amount if purchased from a participating pharmacy. 100% of the cash price if purchased from a non-participating pharmacy. Benefits for orally administered cancer chemotherapy will not be less favorable than the benefits for cancer chemotherapy that is administered intravenously or by injection. Oral chemotherapy must be found to be medically necessary by the treating physician for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in the terms of type, frequency, extent, site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider.	
12. INPATIENT HOSPITAL **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied 50% coinsurance plus all charges in excess of the maximum allowed amount.
13. OUTPATIENT/AMBULATORY SURGERY **Surgical Services are Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied 50% coinsurance, plus all charges in excess of the maximum allowed amount.
Non-Surgical Services are Subject to the Outpatient Professional Services Deductible	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.
14. DIAGNOSTICS **a) Laboratory & x-ray (inpatient services)** **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
(outpatient services) **Subject to the Outpatient Professional Services Deductible**	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied 0% coinsurance plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
14. DIAGNOSTICS (continued) **b) MRI, nuclear medicine, and other high-tech services (inpatient services) Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
(outpatient services) Subject to the Outpatient Professional Services Deductible	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.
	Breast cancer screening with mammography in accordance with the "A" and "B" recommendations of the U.S. Preventive Services Task Force. Notwithstanding the "A" and "B" recommendations of the Task Force, an annual breast cancer screening with mammography shall be covered for all individuals with at least one risk factor.	
15. EMERGENCY CARE[7, 8] Subject to the Inpatient Surgical/Hospital Deductible	After the Inpatient Surgical/Hospital Deductible 30% coinsurance after deductible.	After the Inpatient Surgical/Hospital Deductible 30% coinsurance after deductible.
	Emergency Room services are subject to an additional $100 Copayment per visit which will not be applied towards the Inpatient Surgical/Hospital Deductible or Out-of-Pocket Annual Maximum. The $100 emergency room copayment is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services. Copayment amounts do not apply to the Inpatient Surgical/Hospital Deductible or the Out of Pocket Annual Maximum.	
16. AMBULANCE Subject to the Inpatient Surgical/Hospital Deductible **a) Ground**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.
b) Air	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE Subject to the Outpatient Professional Services Deductible	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Not covered.	
19. OTHER MENTAL HEALTH CARE **a) Inpatient care**	Not covered.	Not covered.
b) Outpatient care	Not covered.	Not covered.
20. ALCOHOL & SUBSTANCE ABUSE	Not covered.	Not covered.

	IN-NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY **a) Inpatient** **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
b) Outpatient Including outpatient therapy for congenital defects and birth abnormalities **Subject to the Outpatient Professional Services Deductible**	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.
	Limited to twenty-four (24) visits per calendar year for physical therapy and occupational therapy; in- and out-of-network combined. Speech therapy is limited to fifty (50) visits per member in each calendar year in- and out-of-network combined. For children, beginning when the child turns three and ceasing when the child turns six, benefits are available, limited to twenty (20) visits each for physical therapy, occupational therapy and/or speech therapy per calendar year; in- and out-of-network combined.	
22. DURABLE MEDICAL EQUIPMENT **(inpatient)** **Inpatient equipment is subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
(outpatient) **Outpatient equipment is subject to the Outpatient Professional Services Deductible**	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.
	Prosthetic devices (arms and legs) benefits are at least equal to those benefits provided under federal law for health insurance for the aged and disabled, if applicable. Any benefit paid for prosthetic devices shall not count toward the annual durable medical equipment maximum reference above. Footwear is limited to a $400 maximum Anthem payment per calendar year, in and out-of-network combined. Wigs are covered up to a maximum Anthem payment of $500 per member per calendar year combined in and out-of-network, with a doctor's prescription.	
23. OXYGEN **(inpatient)** **Inpatient oxygen services are subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
(outpatient) **Outpatient oxygen services are subject to the Outpatient Professional Services Deductible**	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
24. ORGAN TRANSPLANTS **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
25. HOME HEALTH CARE **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
	Limited to sixty (60) visits per member each calendar year, in- and out-of-network combined. Visits are up to four (4) hours or less for each visit.	
26. HOSPICE CARE **a) Inpatient Care** **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
b) Outpatient care **Subject to the Outpatient Professional Services Deductible**	After the Outpatient Professional Services Deductible, 0% coinsurance.	After the Outpatient Professional Services Deductible, 0% coinsurance plus all charges in excess of the maximum allowed amount.
	A benefit period is 91 days. Anthem will cover up to 91-days for routine home care services per benefit period up to three benefit periods, in- and out-of-network combined. Anthem will allow up to $1,150 for Bereavement support services for the covered family members during the twelve-month period following the death of the member. Please see the Hospice section in your certificate for a description of covered services.	
27. SKILLED NURSING FACILITY CARE **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
	Benefits are limited to thirty (30) days per member per year, in– and out-of-network combined for skilled nursing services, wherever they are received.	
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Not covered	Not covered
30. CHIROPRACTIC CARE	Not covered).	Not covered.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Members who desire another professional opinion may obtain a second surgical opinion. Inpatient Respiratory therapy is covered subject to the Inpatient Surgical/Hospital Deductible. Outpatient Respiratory therapy is covered subject to the Outpatient Professional Services Deductible. Respiratory therapy (inpatient and outpatient) is limited to twenty (20) visits per year, in- and out-of-network providers combined. Inpatient Chemotherapy, Hemodialysis, and Radiation Therapy are covered subject to the Inpatient Surgical Hospital Deductible. Outpatient Chemotherapy, Hemodialysis and Radiation Therapy are covered subject to the Outpatient Professional Services Deductible. For treatment by a physician or dentist of an Accidental Injury to the natural teeth, if the injury occurs while you are covered under the Agreement, and the services are received within six months of the injury.	

PART C: LIMITATIONS AND EXCLUSIONS

	IN-NETWORK	OUT-OF-NETWORK
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.[10]	12 months for all pre-existing conditions unless the covered person is a HIPAA-eligible individual as defined under federal and state law or under age 19, in which case there are no pre-existing condition exclusions.	
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"?	For members age 19 and older, a pre-existing condition is an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health-care professional, or took prescription drugs within 12 months immediately preceding the effective date of coverage.	
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 the list to see if a service or treatment you may need is excluded from the policy.	

PART D: USING THE PLAN

36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, 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) 231-5046	
40. Whom do I write/call if I have a complaint? **Whom do I write if I want to file a grievance?[11]**	Anthem Customer Service Department P.O. Box 5747, Denver, CO 80217-5747 (888) 231-5046 Anthem Quality Management 700 Broadway – MC 0532, Denver, CO 80273	
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 # MCOCN559A, individual	
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, 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 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.

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.**

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

Payment for an annual 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.

Mammogram Screenings

All plans except our HMO and PPO Basic Health provide mammogram screening coverage for women in accordance with the "A" and "B" recommendations of the U.S. Preventive Services Task Force. Frequency guidelines can be found in your certificate. Payment for the mammogram screening benefit is based on the plan's provisions for X-ray services.

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. Frequency guidelines can be found in your certificate. Payment for the prostate cancer screening benefit is based on the plan's provisions for X-ray services.

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 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.

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.