Anthem
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Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
Lumenos Plus Health Savings Account (HSA–Compatible) Plans for Individuals
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] (Applicable only to specified covered services. Separate deductibles for In and Out-of-Network; includes prescription drug expenses)	**Individual** $3,000 $4,500 $5,950 per individual	**Family** Family coverage not provided.	**Individual** $3,000 $4,500 $5,950 per individual	**Family** Family coverage not provided.
	After the individual deductible is satisfied, no further deductible is required for the remainder of that calendar year.		After the individual deductible is satisfied, no further deductible is required for the remainder of that calendar year. For non-participating providers, the allowable charge is the maximum benefit allowance. However, even if the deductible has been satisfied, the member will still be responsible for charges from the non-participating provider that are in excess of the maximum allowed amount or where specifically noted in the Certificate or the *Health Benefit Plan Description Form.* Charges in excess of the maximum benefit allowance will not be applied toward the deductible.	

	IN-NETWORK		OUT-OF-NETWORK	
4a. ANNUAL DEDUCTIBLE[2a] (Applicable only to specified covered services. Separate deductibles for In and Out-of-Network; includes prescription drug expenses)	**Individual** Single coverage not provided.	**Family** $3,500 $5,500	**Individual** Single coverage not provided.	**Family** $3,500 $5,500
	Aggregate Family Deductible Under a family membership (two (2) or more members enrolled), no individual deductible applies and the family deductible must be met before Anthem provides benefits. The family deductible amount is met as follows: When one family member has satisfied the family deductible, that family member and all other family members are eligible for benefits. When no family member meets the family deductible, but the family members collectively meet the entire family deductible, then all family members will be eligible for benefits for the remainder of that calendar year. After the family deductible is satisfied, no further deductible is required for the remainder of that calendar year.		**Aggregate Family Deductible** Under a family membership (two (2) or more members enrolled), no individual deductible applies and the family deductible must be met before Anthem provides benefits. The family deductible amount is met as follows: When one family member has satisfied the family deductible, that family member and all other family members are eligible for benefits. When no family member meets the family deductible, but the family members collectively meet the entire family deductible, then all family members will be eligible for benefits for the remainder of that calendar year. After the family deductible is satisfied, no further deductible is required for the remainder of that calendar year. For non-participating providers, the allowable charge is the maximum allowed amount. However, even if the deductible has been satisfied, the member will still be responsible for charges from the non-participating provider that are in excess of the maximum allowed amount or where specifically noted in the Certificate or the *Health Benefit Plan Description Form*. Charges in excess of the maximum allowed amount will not be applied toward the deductible.	

	IN-NETWORK		OUT-OF-NETWORK	
4a. ANNUAL DEDUCTIBLE[2a] (Applicable only to specified covered services. Separate deductibles for In and Out-of-Network; includes prescription drug expenses)	**Individual** Single coverage not provided.	**Family** $7,500 $11,900	**Individual** Single coverage not provided.	**Family** $7,500 $11,900
	Embedded Family Deductible Once the total of allowable charges applying to the deductible for two (2) or more members equal the family deductible, no further deductible will be required for all enrolled members for the remainder of that calendar year. However, no one member can contribute more than half of the family deductible amount to satisfy the family deductible. If an individual family member has satisfied one half of the Embedded Family Deductible, that individual family member only has then satisfied the Embedded Family Deductible for the current plan year with respect to any future claims by that family member. However, until 100% of the Embedded Family Deductible amount has been satisfied, it will continue to apply to all other family members. After the family deductible is satisfied, no further deductible is required for the remainder of that calendar year.		**Embedded Family Deductible** Once the total of allowable charges applying to the deductible for two (2) or more members equal the family deductible, no further deductible will be required for all enrolled members for the remainder of that calendar year. However, no one member can contribute more than half of the family deductible amount to satisfy the family deductible. If an individual family member has satisfied one half of the Embedded Family Deductible, that individual family member only has then satisfied the Embedded Family Deductible for the current plan year with respect to any future claims by that family member. However, until 100% of the Embedded Family Deductible amount has been satisfied, it will continue to apply to all other family members. After the family deductible is satisfied, no further deductible is required for the remainder of that calendar year. For non-participating providers, the allowable charge is the maximum allowed amount. However, even if the deductible has been satisfied, the member will still be responsible for charges from the non-participating provider that are in excess of the maximum allowed amount or where specifically noted in the Certificate or the *Health Benefit Plan Description Form*. Charges in excess of the maximum allowed amount will not be applied toward the deductible.	

	IN-NETWORK		OUT-OF-NETWORK	
5. OUT-OF-POCKET ANNUAL MAXIMUM (Separate for In and Out-of-Network; includes prescription drug expenses)	**Individual** $3,000 $4,500 $5,950 per individual, includes deductible and coinsurance.	**Family** Family coverage not provided	**Individual** $6,000 $9,000 $11,900 per individual, includes deductible and coinsurance.	**Family** Family coverage not provided
			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 or where specifically noted in the certificate or *Health Benefit Plan Description Form* do not count towards satisfying the Out of Pocket Annual Maximum.	
c) Is the deductible included in the out-of-pocket maximum?	Yes		Yes	

	IN-NETWORK		OUT-OF-NETWORK	
5. OUT-OF-POCKET ANNUAL MAXIMUM (Separate for In and Out-of-Network; includes prescription drug expenses)	**Individual** Single coverage not provided.	**Family** $3,500 $5,500 per individual or family, includes deductible and coinsurance	**Individual** Single coverage not provided.	**Family** $7,500 $11,900 per individual or family, includes deductible and coinsurance
	Aggregate Family Out-of-Pocket Maximum Under a family membership, when one family member has satisfied the family out of pocket annual maximum, that family member and all other family members have satisfied the out of pocket annual maximum for that calendar year. When no family member meets the family out of pocket annual maximum on their own, but the family members collectively meet the entire family out of pocket annual maximum, then all family members will have satisfied the out of pocket annual maximum. The individual out of pocket maximum does not apply under a family membership.		**Aggregate Family Out-of-Pocket Maximum** Under a family membership, when one family member has satisfied the family out-of-pocket annual maximum, that family member and all other family members have satisfied the out-of-pocket annual maximum for that calendar year. When no family member meets the family out-of-pocket annual maximum on their own, but the family members collectively meet the entire family out-of-pocket annual maximum, then all family members will have satisfied the out-of-pocket annual maximum and all family members will be eligible for benefits for the remainder of that year. 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 or where specifically noted in the certificate or *Health Benefit Plan Description Form* do not count towards satisfying the Out of Pocket Annual Maximum. Note: The individual out-of-pocket maximum does not apply under a family membership.	

	IN-NETWORK		OUT-OF-NETWORK	
5. OUT-OF-POCKET ANNUAL MAXIMUM (Separate for In and Out-of-Network; includes prescription drug expenses)	**Individual** Single coverage not provided.	**Family** $7,500 $11,900	**Individual** Single coverage not provided.	**Family** $15,000 $23,800
	Embedded Family Out-of-Pocket Maximum Once the total of allowable charges for two (2) or more members equal the Family Out of Pocket Annual Maximum, no family member will be required to pay deductible or coinsurance amounts, except as otherwise required by this Certificate or the *Health Benefit Plan Description Form* for the remainder of that calendar year. However, no one person can contribute more than half of the Family Out-of-Pocket Annual Maximum to satisfy the Family Out-of-Pocket Annual Maximum. If an individual family member has satisfied one half of the Family Out-of-Pocket Annual Maximum, that individual family member only has then satisfied the Out-of-Pocket Annual Maximum for the current plan year with respect to any future claims by that family member. However, until 100% of the Family Out-of-Pocket Annual Maximum amount has been satisfied, it will continue to apply to all other family members.		**Embedded Family Out-of-Pocket Maximum** Once the total of allowable charges for two (2) or more members equal the Family Out of Pocket Annual Maximum, no family member will be required to pay deductible or coinsurance amounts for the remainder of that calendar year except as otherwise required by the Certificate or this *Health Benefit Plan Description Form*. No one person can contribute more than half of the Family Out-of-Pocket Annual Maximum amount to satisfy the Family Out-of-Pocket Annual Maximum. If an individual family member has satisfied one half of the Family Out-of-Pocket Annual Maximum, that individual family member only has then satisfied the Out-of-Pocket Annual Maximum for the current plan year with respect to any future claims by that family member. However, until 100% of the Family Out-of-Pocket Annual Maximum amount has been satisfied, it will continue to apply to all other family members. 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 or those charges specifically noted in the certificate or Health Benefit Plan Description Form do not count towards satisfying the Out of Pocket Annual Maximum.	
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime limits. For benefit limits please see each applicable benefit below.			

	IN-NETWORK	OUT-OF-NETWORK
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
8. MEDICAL OFFICE VISITS[4] **a) Primary Care Providers** **b) Specialists**	 No coinsurance after deductible. No coinsurance after deductible.	 40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount. 40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
9. PREVENTIVE CARE **a) Children's services** Professional services are services provided during a physician office-based visit, including, but not limited to laboratory, X-ray, radiology and pathology services. Please see the Professional Services section of the certificate for a full description of covered professional 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.	$30 copayment per office visit. Deductible waived. No coinsurance required 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. Other covered preventive care services not mandated by Colorado law: 40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
b) Adults' services Professional services are services provided during a physician office-based visit, including, but not limited to laboratory, X-ray, radiology and pathology services. Please see the Professional Services section of the certificate for a full description of covered professional 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.	$30 copayment per office visit. Deductible waived. No coinsurance required for: Routine cytological screening (pap test), mammography benefit in accordance with 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. Other preventive care services not mandated by Colorado law: 40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.	
10. MATERNITY **a) Prenatal care**	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) Delivery & inpatient well baby care[5]	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions** **a) Outpatient care**	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) Prescription Mail Service	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
	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	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
13. OUTPATIENT/AMBULATORY SURGERY	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
14. DIAGNOSTICS **a) Laboratory & x-ray**	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) MRI, nuclear medicine, and other high-tech services	No coinsurance after deductible.	40% coinsurance after deductible, 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]	No coinsurance after deductible.	No coinsurance after deductible.
16. AMBULANCE **a) Ground** **b) Air**	No coinsurance after deductible. No coinsurance after deductible.	No coinsurance after deductible. No coinsurance after deductible.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE **a) Inpatient care**	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Inpatient care islimited to 45 full or 90 partial days per member in each benefit year in- and out-of-network combined.	
b) Outpatient care	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Outpatient care is limited to 20 visits per member in each benefit year in- and out-of-network combined.	

	IN-NETWORK	OUT-OF-NETWORK
20. ALCOHOL & SUBSTANCE ABUSE	Not covered, except for benefits provided for Alcohol misuse screening, behavioral counseling interventions, tobacco use screening of adults and tobacco cessation interventions by outpatient primary care providers.	Not covered, except for benefits provided for Alcohol misuse screening, behavioral counseling interventions, tobacco use screening of adults and tobacco cessation interventions by outpatient primary care providers.
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY **a) Inpatient**	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Covered for inpatient rehabilitation therapy for up to 30 days per member in each benefit year in- and out-of-network combined.	
b) Outpatient	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Speech therapy is limited to 60 visits per member in each benefit year in- and out-of-network combined, except for children to age 6.	
22. DURABLE MEDICAL EQUIPMENT	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	For 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.	
23. OXYGEN	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
24. ORGAN TRANSPLANTS	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
25. HOME HEALTH CARE	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Limited to 60 visits per member in each benefit year, in- and out-of-network combined.	
26. HOSPICE CARE **a) Inpatient Care**	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) Outpatient care	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Bereavement support services for the covered family members during the twelve-month period following the death of the member are limited to a maximum total payment of $1,150. 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. Please see the Hospice section in your certificate for a description of covered services.	

	IN-NETWORK	OUT-OF-NETWORK
27. SKILLED NURSING FACILITY CARE	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Limited to 100 visits per member in each benefit year, in- and out-of-network combined.	
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Not covered	Not covered
30. CHIROPRACTIC CARE	No coinsurance after deductible. Limited to 12 visits per member in each benefit year combined with acupuncture care (see line 31).	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	**Acupuncture care:** No coinsurance after deductible. Limited to 12 visits per member in each benefit year combined with chiropractic care (see line 30).	Not covered
	Benefits are provided for diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams (no coinsurance after deductible). Insulin pumps and related supplies are covered subject to meeting Anthem's medical policy criteria. When diabetic supplies are provided by a pharmacy they are covered under the prescription drug benefit and subject to the prescription copayment. Members who desire another professional opinion may obtain a second surgical opinion.	Benefits are provided for diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams (40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount). Insulin pumps and related supplies are covered subject to meeting Anthem's medical policy criteria. When diabetic supplies are provided by a pharmacy they are covered under the prescription drug benefit and subject to the prescription copayment. Members who desire another professional opinion may obtain a second surgical opinion.
	Healthy Rewards Listed below are resources Anthem has available for its members to help promote the members well-being. • Complete Health Assessment • Enroll in and graduate from a Personal Health Coach Program • Complete Smoking Cessation Program (for members over the age of 18) • Complete Weight Management Program (for members over the age of 18 with a BMI or 25 or greater)	

PART C: LIMITATIONS AND EXCLUSIONS

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?	Yes, unless the individual is a HIPAA-eligible individual as defined under federal and state law.

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. 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, 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?	(866) 837-4597	
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 17549, Denver, CO 80217-7549 (888) 224-4911 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 #MCOCN477A, 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

All plans provide coverage for an annual Pap test and the related office visit. Payment for the Pap test is based on the plan's laboratory services provisions, and payment for the related office visit is based on the plan's preventive care provisions.

Mammogram Screenings

All plans except our HMO and PPO Basic Health Plans 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.