

Colorado Health Plan Description Form Anthem Blue Cross and Blue Shield BluePreferred for Individuals

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.

4. ANNUAL DEDUCTIBLE	IN-NETWORK		OUT-OF-NETWORK	
	Individual	Family	Individual	Family
500/5000	\$500	\$500 per family member	\$1,000	\$1,000 per family member
1000/5000	\$1,000	\$1,000 per family member	\$2,000	\$2,000 per family member
2000/5000	\$2,000	\$2,000 per family member	\$4,000	\$4,000 per family member
500/10000	\$500	\$500 per family member	\$1,000	\$1,000 per family member
1000/10000	\$1,000	\$1,000 per family member	\$2,000	\$2,000 per family member
2000/10000	\$2,000	\$2,000 per family member	\$4,000	\$4,000 per family member
3000/10000	\$3,000	\$3,000 per family member	\$6,000	\$6,000 per family member
5. OUT-OF-POCKET ANNUAL MAXIMUM ²	Dollar amount below + deductible, excluding any copays.			
	Individual	Family	Individual	Family
500/5000	\$1,000	\$1,000 per family member	\$2,000	\$2,000 per family member
1000/5000	\$1,000	\$1,000 per family member	\$2,000	\$2,000 per family member
2000/5000	\$1,000	\$1,000 per family member	\$2,000	\$2,000 per family member
500/10000	\$2,000	\$2,000 per family member	\$4,000	\$4,000 per family member
1000/10000	\$2,000	\$2,000 per family member	\$4,000	\$4,000 per family member
2000/10000	\$2,000	\$2,000 per family member	\$4,000	\$4,000 per family member
3000/10000	\$2,000	\$2,000 per family member	\$4,000	\$4,000 per family member
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$2,000,000 per member (combined in and out-of-network)		\$2,000,000 per member (combined in and out-of-network)	
7A. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO Provider Network. See provider directory for complete list of current providers.		All providers licensed or certified to provide covered benefits.	
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable. This is not a network plan.		Not applicable. This is not a network plan.	
8. ROUTINE MEDICAL OFFICE VISITS				
500/5000, 1000/5000, 2000/5000, 500/10000, 1000/10000, 2000/10000	\$25 copay for office visit only. Preventive services are limited. See Section 9.		60% after deductible	
3000/10000	80% after deductible. Preventive services are limited. See Section 9.		60% after deductible	

	IN-NETWORK	OUT-OF-NETWORK
9. PREVENTIVE CARE a) Children's services b) Adults' services 500/5000, 1000/5000, 2000/5000, 500/10000, 1000/10000, 2000/10000 3000/10000	80%, not subject to deductible for age-appropriate visits and routine immunizations Not covered except for one annual pap test \$25 copay for office visit and \$75 maximum payment for laboratory test; mammogram screening up to \$75 maximum payment; and prostate screening up to \$65 Not covered except for one annual pap test 80% after deductible for office visit and \$75 maximum payment for laboratory test; mammogram screening up to \$75 maximum payment; and prostate screening up to \$65 maximum payment	60%, not subject to deductible for age-appropriate visits and routine immunizations Not covered except for mammogram screening up to \$75 maximum payment; and prostate screening up to \$65 maximum payment; combined in- and out-of-network Not covered except for mammogram screening up to \$75 maximum payment; and prostate screening up to \$65 maximum payment; combined in- and out-of-network.
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care	Not covered Delivery not covered, inpatient well baby care 80% after deductible	Not covered Delivery not covered, inpatient well baby care 60% after deductible
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions a) Inpatient care b) Outpatient care c) Prescription Mail Service	Included with inpatient hospital (see line 12) Tier 1 generic formulary \$15, tier 2 brand formulary \$40, tier 3 non-formulary \$60 at a participating pharmacy up to a 34-day supply. Tier 1 generic formulary \$30, tier 2 brand formulary \$80, tier 3 non-formulary \$120 through the mail order service up to a 90-day supply. For drugs on our approved list, contact Customer Service at 1-800-423-6174. Covered only when received from a participating pharmacy.	Included with inpatient hospital (see line 12) Not covered Not covered
12. INPATIENT HOSPITAL	80% after deductible	60% after deductible
13. OUTPATIENT/AMBULATORY SURGERY	80% after deductible	60% after deductible
14. LABORATORY AND X-RAY a) Inpatient care b) Outpatient care	Included with inpatient hospital (see line 12) 80% after deductible	Included with inpatient hospital (see line 12) 60% after deductible
15. EMERGENCY CARE³	80% after deductible	60% after deductible
16. AMBULANCE a) Ground b) Air	Paid as out-of-network Paid as out-of-network	60% after deductible (maximum benefit of \$350) 60% after deductible (maximum benefit of \$5,000)
17. URGENT, NON-ROUTINE, AFTER HOURS CARE a) Inpatient care b) Outpatient care	80% after deductible 80% after deductible	60% after deductible 60% after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁴	See line 19, Other Mental Health Care	See line 19, Other Mental Health Care

	IN-NETWORK	OUT-OF-NETWORK
19. OTHER MENTAL HEALTH CARE		
a) Inpatient care	50% of allowed charges (limited to 45 full or 90 partial days per member in each benefit year, combined with out-of-network)	50% of allowed charges (limited to 45 full or 90 partial days per member in each benefit year, combined with out-of-network)
b) Outpatient care	50% of allowed charges (up to a maximum of \$500 per member in each benefit year, combined with out-of-network)	50% of allowed charges (up to a maximum of \$500 per member in each benefit year, combined with in-network)
	Maximum payment for inpatient and outpatient care is limited to \$10,000 per member per lifetime.	Maximum payment for inpatient and outpatient care is limited to \$10,000 per member per lifetime.
20. ALCOHOL & SUBSTANCE ABUSE		
a) Inpatient Care	Not covered	Not covered
b) Outpatient care	Not covered	Not covered
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY		
a) Inpatient	Covered when received as part of a inpatient hospital admission for acute care and for rehabilitation therapy for up to 30 days per illness or injury	Covered when received as part of a inpatient hospital admission for acute care and for rehabilitation therapy for up to 30 days per illness or injury
b) Outpatient	80% after deductible (speech therapy limited to 60 visits per member in each benefit year, combined with out-of-network, except for children to age 5)	60% after deductible (speech therapy limited to 60 visits per member in each benefit year, combined with out-of-network, except for children to age 5)
22. DURABLE MEDICAL EQUIPMENT		
a) Inpatient care	Included with inpatient hospital (see line 12)	Included with inpatient hospital (see line 12)
b) Outpatient care	80% after deductible. See policy for types and circumstances of coverage.	60% after deductible. See policy for types and circumstances of coverage.
23. OXYGEN		
a) Inpatient care	Included with inpatient hospital (see line 12)	Included with inpatient hospital (see line 12)
b) Outpatient care	80% after deductible	60% after deductible
24. ORGAN TRANSPLANTS	80% after deductible. See policy for details.	60% after deductible. See policy for details.
25. HOME HEALTH CARE	80% after deductible (limited to 60 visits per member in each benefit year, combined with out-of-network)	60% after deductible (limited to 60 visits per member in each benefit year, combined with in-network)
26. HOSPICE CARE		
a) Inpatient Care	80% after deductible (limited to 30 visits per member in each benefit year, combined with out-of-network)	60% after deductible (limited to 30 visits per member in each benefit year, combined with in-network)
b) Outpatient care	80% (limited to 91 days per member in each benefit year, combined with out-of-network)	60% after deductible (limited to 91 days per member in each benefit year, combined with in-network)
27. SKILLED NURSING FACILITY CARE	Not covered	Not covered
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Vision benefits included in the plan. Information can be found on the separate Anthem Vision Summary Plan Description starting on page 11.	
30. CHIROPRACTIC CARE	Not covered	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	\$500 additional accident benefits per member per accident in allowed charges When a member desires another professional opinion, they may obtain a second surgical opinion.	\$500 additional accident benefits per member per accident in allowed charges When a member desires another professional opinion, they may obtain a second surgical opinion.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. ⁵	12 months for all pre-existing conditions unless the covered person is a HIPPA-eligible individual as defined under federal and state law, 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 HIPPA-eligible individual as defined under federal and state law
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	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	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?	303-831-2391 or 1-800-423-6174	
40. Whom do I write/call if I have a complaint or want to file a grievance? ⁶	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway Denver, CO 80273 303-831-2391 or 1-800-423-6174	
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 #'s 96319, individual	

PART E: COST

43. What is the cost of this plan?	Contact your agent, this insurance company, or your employer, as appropriate, to find out the premium for this plan. In some cases, plan costs are included with this form.
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PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES, ADMINISTRATION AND PROFIT

<p>Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan, may request answers to the questions listed below. The request may be made orally or in writing to the agent marketing the plan or directly to the insurance company and shall be answered within five (5) working days of the receipt of the request.</p> <ul style="list-style-type: none"> • What are the three most frequently used methods of payment for primary care physicians? • What are the three most frequently used methods of payment for physician specialists? • What other financial incentives determine physician payment? • What percentage of total Colorado premiums are spent on health-care expenses as distinct from administration and profit?

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 "Out-of-pocket maximum" The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan.