

## 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? <sup>1</sup>	Yes, but the patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

### PART B: SUMMARY OF BENEFITS

**Important Note:** This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage.

	IN-NETWORK		OUT-OF-NETWORK	
	Individual	Family	Individual	Family
<b>4. ANNUAL DEDUCTIBLE</b>				
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
<b>5. OUT-OF-POCKET ANNUAL MAXIMUM<sup>2</sup></b>	<b>Dollar amount below + deductible, excluding any copays.</b>			
	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
<b>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</b>	\$2,000,000 per member (combined in and out-of-network)		\$2,000,000 per member (combined in and out-of-network)	
<b>7A. COVERED PROVIDERS</b>	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.	
<b>7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?</b>	Not applicable. This is not a network plan.		Not applicable. This is not a network plan.	
<b>8. ROUTINE MEDICAL OFFICE VISITS</b>				
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
<b>9. PREVENTIVE CARE</b> <b>a) Children's services</b>  <b>b) Adults' services</b> <b>500/5000, 1000/5000, 2000/5000,</b> <b>500/10000, 1000/10000,</b> <b>2000/10000</b>  <b>3000/10000</b>	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.
<b>10. MATERNITY</b> <b>a) Prenatal care</b> <b>b) Delivery &amp; inpatient well baby care</b>	Not covered Delivery not covered, inpatient well baby care 80% after deductible	Not covered Delivery not covered, inpatient well baby care 60% after deductible
<b>11. PRESCRIPTION DRUGS</b> <b>Level of coverage and restrictions on prescriptions</b> <b>a) Inpatient care</b>  <b>b) Outpatient care</b>  <b>c) Prescription Mail Service</b>	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
<b>12. INPATIENT HOSPITAL</b>	80% after deductible	60% after deductible
<b>13. OUTPATIENT/AMBULATORY SURGERY</b>	80% after deductible	60% after deductible
<b>14. LABORATORY AND X-RAY</b> <b>a) Inpatient care</b> <b>b) Outpatient care</b>	Included with inpatient hospital (see line 12) 80% after deductible	Included with inpatient hospital (see line 12) 60% after deductible
<b>15. EMERGENCY CARE<sup>3</sup></b>	80% after deductible	60% after deductible
<b>16. AMBULANCE</b> <b>a) Ground</b>  <b>b) Air</b>	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)
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b> <b>a) Inpatient care</b> <b>b) Outpatient care</b>	80% after deductible 80% after deductible	60% after deductible 60% after deductible
<b>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE<sup>4</sup></b>	See line 19, Other Mental Health Care	See line 19, Other Mental Health Care

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>19. OTHER MENTAL HEALTH CARE</b> a) Inpatient care  b) Outpatient 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 (up to a maximum of \$500 per member in each benefit year, combined with out-of-network)  Maximum payment for inpatient and outpatient care is limited to \$10,000 per member per lifetime.	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 (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.
<b>20. ALCOHOL &amp; SUBSTANCE ABUSE</b> a) Inpatient Care b) Outpatient care	Not covered Not covered	Not covered Not covered
<b>21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY</b> a) Inpatient  b) Outpatient	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  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)	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  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)
<b>22. DURABLE MEDICAL EQUIPMENT</b> a) Inpatient care b) Outpatient care	Included with inpatient hospital (see line 12) 80% after deductible. See policy for types and circumstances of coverage.	Included with inpatient hospital (see line 12) 60% after deductible. See policy for types and circumstances of coverage.
<b>23. OXYGEN</b> 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
<b>24. ORGAN TRANSPLANTS</b>	80% after deductible. See policy for details.	60% after deductible. See policy for details.
<b>25. HOME HEALTH CARE</b>	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)
<b>26. HOSPICE CARE</b> a) Inpatient Care  b) Outpatient care	80% after deductible (limited to 30 visits per member in each benefit year, combined with out-of-network)  80% (limited to 91 days 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)  60% after deductible (limited to 91 days per member in each benefit year, combined with in-network)
<b>27. SKILLED NURSING FACILITY CARE</b>	Not covered	Not covered
<b>28. DENTAL CARE</b>	Not covered	Not covered
<b>29. VISION CARE</b>	Vision benefits included in the plan. Information can be found on the separate Anthem Vision Summary Plan Description starting on page 11.	
<b>30. CHIROPRACTIC CARE</b>	Not covered	Not covered
<b>31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)</b>	\$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**

<b>32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.<sup>5</sup></b>	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..
<b>33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?</b>	Yes, unless the individual is a HIPPA-eligible individual as defined under federal and state law
<b>34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?</b>	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.
<b>35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?</b>	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**

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?</b>	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield
<b>37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</b>	Yes	Yes
<b>38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b>	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
<b>39. What is the main customer service number?</b>	303-831-2391 or 1-800-423-6174	
<b>40. Whom do I write/call if I have a complaint or want to file a grievance?<sup>6</sup></b>	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway Denver, CO 80273 303-831-2391 or 1-800-423-6174	
<b>41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?</b>	<b>Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202</b>	
<b>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.</b>	Policy form #'s 96319, individual	

**PART E: COST**

<b>43. What is the cost of this plan?</b>	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**

**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.**

- 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?

<sup>1</sup> “Network” refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

<sup>2</sup> “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.

<sup>3</sup> “Emergency care” means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb-threatening emergency existed.

<sup>4</sup> “Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

<sup>5</sup> Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

<sup>6</sup> Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.





## ANTHEM VISION SUMMARY PLAN DESCRIPTION

*This Summary Plan Description outlines the vision benefits available to you through the Anthem Vision Plan. This is a summary of your vision benefit. Please review your benefit certificate for plan details. For eligibility definitions please contact your group administrator.*

**Anthem's Provider Network:** Anthem Vision contracts with many providers which include independent optometrists and ophthalmologists as well as retail locations. Anthem members have access to approximately 10,000 conveniently located providers nationwide. Members may call Anthem Vision toll-free (800) 231-2583 or visit [www.anthem.com](http://www.anthem.com) any time for provider locations. Schedule an appointment with your Anthem provider; identify yourself as an Anthem member for fast, paperless determination and confirmation of benefits.

**Network Provider:** Maximum benefits are achieved when members access their benefits from an *Anthem* Participating Provider. Copayment(s) may apply to in-network benefits.

**Non-Network Provider Reimbursements:** Members may go to a non-participating (non-network) provider and pay the provider directly for services and materials. Members may then submit an original itemized invoice and a copy of the prescription along with the Member's I.D. number to *Anthem Vision* for reimbursement according to the Non-Network Reimbursement schedule identified in this Summary Plan Description.

**Value Added Savings:** *Anthem Providers* agree to Preferred Pricing that is significantly below retail. Members are able to achieve substantial savings on additional pair purchases, contact lenses, lens treatments, specialized lenses and various sundry items. Members may save approximately 20% to 40% or more off retail when they visit an *Anthem* Provider.

**Copayment(s):** Copayment amounts are applicable to Network Provider examinations and materials. Separate copayments may be charged for examinations and materials. Materials consist of lenses and frames or contact lenses. Separate copayments for lenses and frames will not apply if these services are received at the same time.

<b><i>Anthem Vision Benefits</i></b>	<b>Member Benefit from Network Provider</b>	<b>Non-Network Reimbursement**</b>
<b><i>Vision Examination:</i></b> Each member is entitled to a comprehensive vision examination by an Anthem Provider. <b><i>Availability : Once every 12 months*</i></b>	<b>\$25.00 Copayment</b>	<b>Up to \$35.00</b>
<b><i>Lenses:</i></b> A choice of glass or plastic (CR39) lenses in single vision, and bifocal or trifocal (FT 25-28); lenses up to 55 mm; and all ranges of prescriptions. <b>Single Vision Lenses</b> <b>Bifocal Lenses (pair)</b> <b>Progressive Lenses (pair)</b> <b>Trifocal Lenses (pair)</b> <b>Lenticular</b> <b><i>Availability : Once every 12 months*</i></b>	<b>\$25.00 Materials copayment applies to lenses and frames</b> <b>\$25.00 Copayment</b> <b>\$25.00 Copayment</b> <b>\$25.00 Copayment</b> <b>– Maximum Allowable Amount equal to bifocal amount. Member pays difference.</b> <b>\$25.00 Copayment</b> <b>\$25.00 Copayment</b>	<b>Up to \$25.00</b> <b>Up to \$40.00</b> <b>Up to \$40.00</b> <b>Up to \$55.00</b> <b>Up to \$80.00</b>
<b><i>Frames:</i></b> Maximum Allowable Amount of <b>\$120.00</b> (retail) for frames purchased from Network Provider. Member pays Preferred Price in excess of Maximum Allowable Amount. <b><i>Availability : Once every 24 months*</i></b>	<b>\$25.00 Copayment</b>	<b>Up to \$45.00</b>
<b><i>Contact Lenses***:</i></b> <b>Elective -</b> Members have a <b>\$105.00</b> plan allowance per benefit period toward cosmetic contact lenses <i>in lieu of the frame and lens benefits</i> . If the member chooses contact lenses greater than the plan allowance, the member is responsible for the difference. <b>Medically Necessary</b> <b><i>Availability : Once every 12 months*</i></b>	<b>\$25.00 Copayment</b> <b>Plan provides 10% discount on disposable lenses and 15% on other traditional lenses.</b> <b>\$25.00 Copayment</b>	<b>Up to \$80.00</b> <b>Up to \$210.00</b>

*\*From your last date of service*

*\*\* Non-Network Reimbursement represents Plan's allowance towards eligible benefits and may not cover all charges.*

*\*\*\*See Membership Certificate for definitions of Elective and Medically Necessary Contact Lenses.*

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the Plan Design; however, these materials and any items not covered below may be purchased at Preferred Pricing from an Anthem Vision Provider. In addition, benefits are payable only for expenses incurred while the Group and individual Member coverage is in force.

Orthoptics or vision training and any supplemental testing; Plano (non- prescription) lenses; or two pair of eyeglasses in lieu of bifocals or trifocals.

Medical or surgical treatment of the eyes.

An eye exam or corrective eyewear required by an employer as a condition of employment.

Any injury or illness covered under Workers' Compensation or similar law, or which is work related.

Sub-normal vision aids.

Plain or prescription sunglasses or tinted lenses, and no-line bifocals and blended lenses.

Charges in excess of Usual and Customary for services and materials.

Experimental or non-conventional treatments or devices.

Safety eyewear.

Spectacle lens styles, materials, treatments or "add-ons" not shown in the Summary Plan Description.