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Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
Colorado Individual CoreShare Plus Plan
Effective September 23, 2010

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]	**Individual[2b]**	**Family[2c]**	**Individual**	**Family**
	$750	$1,500	$750	$1,500
	$1,500	$3,000	$1,500	$3,000
	$2,500	$5,000	$2,500	$5,000
	$3,500	$7,000	$3,500	$7,000
	$5,000	$10,000	$5,000	$10,000
	$7,500	$15,000	$7,500	$15,000
	$10,000	$20,000	$10,000	$20,000
	$15,000	$30,000	$15,000	$30,000
	$25,000	$50,000	$25,000	$50,000
5. OUT-OF-POCKET ANNUAL MAXIMUM **Includes deductible, copayments and coinsurance**	**Individual[3]**	**Family**	**Individual**	**Family**
	$4,250	$8,500	$8,250	$16,500
	$5,000	$10,000	$9,000	$18,000
	$6,000	$12,000	$10,000	$20,000
	$7,000	$14,000	$11,000	$22,000
	$8,500	$17,000	$12,500	$25,000
	$11,000	$22,000	$15,000	$30,000
	$10,000	$20,000	$17,500	$35,000
	$15,000	$30,000	$22,500	$45,000
	$25,000	$50,000	$32,500	$65,000
	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			

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.

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	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		
For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible	70% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
For $10,000, $15,000 and $25,000 plans:	No coinsurance after deductible	30% coinsurance after deductible plus all charges in excess of the maximum benefit allowance.
b) Specialists		
For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance after deductible plus all charges in excess of the maximum benefit allowance.
For $10,000, $15,000 and $25,000 plans:	No coinsurance after deductible	30% coinsurance after deductible plus all charges in excess of the maximum benefit allowance.

	IN-NETWORK	OUT-OF-NETWORK
9. PREVENTIVE CARE (All plans) **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.	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. All other preventive services are not covered.

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE (All plans) (continued) **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.	Deductible waived. No coinsurance required 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 services are not covered.
	Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.	
10. MATERNITY **a) Prenatal care**	**Not covered** except for complications of pregnancy.	**Not covered** except for complications of pregnancy.
b) Delivery & inpatient well baby care[5] For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	Delivery not covered. 50% coinsurance after deductible for inpatient newborn care.	Delivery not covered. 70% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance, for inpatient newborn care.
For $10,000, $15,000 and $25,000 plans:	Delivery not covered. No coinsurance after deductible for inpatient newborn care.	Delivery not covered. 30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance, for inpatient newborn care.

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions** **(All plans)**		
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 $2000 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied: • $35 copayment for each prescription and/or refill for a maximum thirty (30) day supply. **Tier 3 Pharmacy Drugs:** After the $2,000 Tier2 and Tier 3 Prescription Drug Deductible has been satisfied: • 25% coinsurance for each prescription and/or refill for a maximum thirty (30) day supply.	Not covered
b) Prescription Mail Service	**Mail Order:** • **Tier 1 Prescription Drugs:** $45.00 copayment for each prescription and/or refill up to a maximum ninety (90) day supply. **Tier 2 Prescription Drugs:** After a $2000 per member per calendar year Tier 2 and Tier 3 Prescription Drug Deductible is satisfied: • $105.00 copayment for each prescription and/or refill up to a maximum ninety (90) day supply. **Tier 3 Prescription Drugs:** After a $2000 per member per calendar year Tier 2 and Tier 3 Prescription Drug Deductible is satisfied: • 25% of negotiated fee for each prescription and/or refill up to a maximum ninety (90) day supply.	Not covered

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions (continued)**	**Tier 3 Prescription Drug Out of Pocket Maximum** There is a $2500 Tier 3 Out-of-Pocket maximum per member per calendar year when purchased from a participating pharmacy. You will not be required to pay more than $2500 per member per calendar year for prescription drugs purchased at a participating pharmacy. Once the Tier 3 Prescription Drug Out of Pocket Maximum is met, no further Coinsurance will be required for drugs purchased from a participating pharmacy for the remainder of that calendar year. Copayments for Tier 1 and Tier 2 drugs will not accumulate towards the Tier 3 Prescription Drug Out of Pocket Maximum, and will continue to be required even after the Tier 3 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 **These benefits apply only to prescription drugs listed on the Plan Formulary. Non-Formulary Prescription Drug are not covered.** **Note:** Charges for Non-Formulary Prescription Drugs will not be applied towards the Tier 2 and Tier 3 Prescription Drug Deductible or the Tier 3 Prescription Drug Out of Pocket Maximum.	
12. INPATIENT HOSPITAL For $750, $1,500, $2,500 plans:	$500 inpatient facility copayment per day up to three (3) days per admission, then 50% coinsurance after deductible.	$500 inpatient facility copayment per day up to three (3) days, then 70% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
For $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
For $10,000, $15,000 and $25,000 plans:	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
	Facility copayments will not apply towards the deductible or out-of-pocket annual maximum and will still be required after out-of-pocket maximum is met.	
13. OUTPATIENT/AMBULATORY SURGERY For $750, $1,500, $2,500 plans:	$200 outpatient surgery facility copayment per admission, then 50% coinsurance after deductible.	$200 outpatient surgery facility copayment per admission, then 70% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
For $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
For $10,000, $15,000 and $25,000 plans:	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
	No outpatient surgery facility copayment will be required if admitted as inpatient within 72 hours of initial outpatient hospital admission. Facility copayments will not apply towards the deductible or out-of-pocket annual maximum and will still be required after out-of-pocket maximum is met.	

	IN-NETWORK	OUT-OF-NETWORK
14. DIAGNOSTICS **a) Laboratory & x-ray** For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
For $10,000, $15,000 and $25,000 plans:	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
b) MRI, nuclear medicine, and other high-tech services For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance
For $10,000, $15,000 and $25,000 plans:	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
15. EMERGENCY CARE[7, 8] For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	50% coinsurance after deductible.
For $10,000, $15,000 and $25,000 plans:	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
16. AMBULANCE **a) Ground** For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	50% coinsurance after deductible.
For $10,000, $15,000 and $25,000 plans:	No coinsurance after deductible.	30% coinsurance after deductible.
b) Air For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	50% coinsurance after deductible.
For $10,000, $15,000 and $25,000 plans:	No coinsurance after deductible.	30% coinsurance after deductible.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
For $10,000, $15,000 and $25,000 plans:	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Coverage is no less extensive than the coverage provided for any other physical illness.	

	IN-NETWORK	OUT-OF-NETWORK
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
For $10,000, $15,000 and $25,000 plans:	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
b) Outpatient care For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
For $10,000, $15,000 and $25,000 plans:	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
	Anthem will cover other mental health care and alcohol & substance abuse benefits up to a maximum of thirty (30) days per member per calendar Year, In-Network and Out-of-Network providers combined for inpatient care. Anthem will cover other mental health care and alcohol & substance abuse benefits up to a maximum of forty-eight (48) visits per member per calendar year In-Network and Out-of-Network providers combined for outpatient care.	
20. ALCOHOL & SUBSTANCE ABUSE For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
For $10,000, $15,000 and $25,000	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
	Anthem will cover other mental health care and alcohol & substance abuse benefits up to a maximum of thirty (30) days per member per calendar Year, In-Network and Out-of-Network providers combined for inpatient care. Anthem will cover other mental health care and alcohol & substance abuse benefits up to a maximum of forty-eight (48) visits per member per calendar year In-Network and Out-of-Network providers combined for outpatient care.	

	IN-NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY **a) Inpatient**		
For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
For $10,000, $15,000 and $25,000	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
b) Outpatient Including outpatient therapy for congenital defects and birth abnormalities		
For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
For $10,000, $15,000 and $25,000	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
	Limited to twenty-four (24) visits per calendar year for physical therapy, occupational therapy, and/or chiropractic therapy; in- and out-of-network combined. Speech therapy is limited to twenty (20) visits per member in each calendar year in- and out-of-network combined. Benefits are available up to a member's 6th birthday, 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		
For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
For $10,000, $15,000 and $25,000	No coinsurance after deductible.	No coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
	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		
For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
For $10,000, $15,000 and $25,000	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.

	IN-NETWORK	OUT-OF-NETWORK
24. ORGAN TRANSPLANTS		
For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible	70% coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
For $10,000, $15,000 and $25,000	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
24. HOME HEALTH CARE		
For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
For $10,000, $15,000 and $25,000	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
	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		
For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
For $10,000, $15,000 and $25,000	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
b) Outpatient care		
For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
For $10,000, $15,000 and $25,000	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
	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.	

	IN-NETWORK	OUT-OF-NETWORK
27. SKILLED NURSING FACILITY CARE For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum benefit allowance, after deductible.
For $10,000, $15,000 and $25,000	No coinsurance after deductible.	30% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
	Benefits are limited to twenty (20) days per member per year, in- and out-of-network combined for skilled nursing services, wherever they are received.	
28. DENTAL CARE (All plans)	Not covered	Not covered
29. VISION CARE (All plans)	Not covered	Not covered
30. CHIROPRACTIC CARE (All plans)	Covered under PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY (see line 21).	Covered under PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY (see line 21).
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) (All plans)	Members who desire another professional opinion may obtain a second surgical opinion. Respiratory therapy is limited to twenty (20) visits per year, in- and out-of-network providers combined. 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

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

	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?	(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 # MCOCN3933A, 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.