Anthem

Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
Lumenos® Health Savings Account (HSA–Compatible) Plans for Individuals
Effective February 1, 2008

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]	Benefit Year	Benefit Year	Benefit Year	Benefit Year
4a. ANNUAL DEDUCTIBLE[2a]	Single[2b]	Non-single[2c]	Sngle[2b]	Non-single [2c]
1500/3000/100%	$1,500	$3,000 per family member	$3,000	$6,000 per family member
1500/3000/70%	$1,500	$3,000 per family member	$3,000	$6,000 per family member
2500/5000/100%	$2,500	$5,000 per family member	$5,000	$10,000 per family member
2500/5000/80%	$2,500	$5,000 per family member	$5,000	$10,000 per family member
3000/6000/100%	$3,000	$6,000 per family member	$6,000	$12,000 per family member
3000/6000/80%	$3,000	$6,000 per family member	$6,000	$12,000 per family member
5000/10000/100%	$5,000	$10,000 per family member	$10,000	$20,000 per family member
	When one individual has satisfied the family deductible, that individual and all other family members are eligible for benefits.			
5. OUT-OF-POCKET ANNUAL MAXIMUM	Individual[3]	Family	Individual[3]	Family
1500/3000/100%	$1,500	$3,000 per family member	$4,500	$9,000 per family member.
1500/3000/70%	$5,000	$10,000 per family member	$10,000	$20,000 per family member
2500/5000/100%	$2,500	$5,000 per family member	$7,500	$15,000 per family member
2500/5000/80%	$5,000	$10,000 per family member	$10,000	$20,000 per family member
3000/6000/100%	$3,000	$6,000 per family member	$9,000	$18,000 per family member
3000/6000/80%	$5,000	$10,000 per family member	$10,000	$20,000 per family member
5000/10000/100%	$5,000	$10,000 per family member	$15,000	$30,000 per family member
	If you select family membership, no individual out-of-pocket annual maximum applies and the family out-of-pocket annual maximum must be met before Anthem provides benefits. The family out-of-pocket annual maximum amount is met as follows: when one individual has satisfied the family out-of-pocket maximum, that family member and all other family members are eligible for benefit.		Yes	
Is deductible included in the out-of-pocket maximum?	Yes			

An independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks Blue Cross and Blue Shield Association

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

	IN-NETWORK	OUT-OF-NETWORK
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$5,000,000 per member in- and out-of-network combined for all covered services.	$5,000,000 per member in- and out-of-network combined for all covered services.
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		
1500/3000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
1500/3000/70%	30% coinsurance after deductible.	50% coinsurance after deductible.
2500/5000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
2500/5000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
3000/6000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
3000/6000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
5000/10000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
b) Specialists		
1500/3000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
1500/3000/70%	30% coinsurance after deductible.	50% coinsurance after deductible.
2500/5000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
2500/5000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
3000/6000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
3000/6000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
5000/10000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
9. PREVENTIVE CARE		
a) Children's services		
1500/3000/100%	No coinsurance.	30% coinsurance after deductible.
1500/3000/70%	No coinsurance.	50% coinsurance after deductible.
2500/5000/100%	No coinsurance.	30% coinsurance after deductible.
2500/5000/80%	No coinsurance.	40% coinsurance after deductible.
3000/6000/100%	No coinsurance.	30% coinsurance after deductible.
3000/6000/80%	No coinsurance.	40% coinsurance after deductible.
5000/10000/100%	No coinsurance.	30% coinsurance after deductible.
	Not subject to deductible For age-appropriate visits and routine immunizations (up to age 13).	For age-appropriate visits and routine immunizations (up to age 13).
b) Adults' services		
1500/3000/100%	No coinsurance.	30% coinsurance after deductible.
1500/3000/70%	No coinsurance.	50% coinsurance after deductible.
2500/5000/100%	No coinsurance.	30% coinsurance after deductible.
2500/5000/80%	No coinsurance.	40% coinsurance after deductible.
3000/6000/100%	No coinsurance.	30% coinsurance after deductible.
3000/6000/80%	No coinsurance.	40% coinsurance after deductible.
5000/10000/100%	No coinsurance.	30% coinsurance after deductible.
	Not subject to deductible. Mammogram screening and prostate screening are covered and are not subject to deductible or coinsurance.	Mammogram screening and prostate screening are covered and are not subject to deductible or coinsurance.

	IN-NETWORK	OUT-OF-NETWORK
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]	Delivery not covered. For inpatient well baby care:	Delivery not covered. For inpatient well baby care:
1500/3000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
1500/3000/70%	30% coinsurance after deductible.	50% coinsurance after deductible.
2500/5000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
2500/5000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
3000/6000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
3000/6000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
5000/10000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions		
a) Outpatient care		
1500/3000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
1500/3000/70%	30% coinsurance after deductible.	50% coinsurance after deductible.
2500/5000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
2500/5000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
3000/6000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
3000/6000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
5000/10000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
b) Prescription Mail Service		
1500/3000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
1500/3000/70%	30% coinsurance after deductible.	50% coinsurance after deductible.
2500/5000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
2500/5000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
3000/6000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
3000/6000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
5000/10000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
12. INPATIENT HOSPITAL		
1500/3000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
1500/3000/70%	30% coinsurance after deductible.	50% coinsurance after deductible.
2500/5000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
2500/5000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
3000/6000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
3000/6000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
5000/10000/100%	No coinsurance after deductible.	30% coinsurance after deductible.

	IN-NETWORK	OUT-OF-NETWORK
13. OUTPATIENT/AMBULATORY SURGERY		
1500/3000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
1500/3000/70%	30% coinsurance after deductible.	50% coinsurance after deductible.
2500/5000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
2500/5000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
3000/6000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
3000/6000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
5000/10000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
14. DIAGNOSTICS		
a) Laboratory & x-ray		
1500/3000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
1500/3000/70%	30% coinsurance after deductible.	50% coinsurance after deductible.
2500/5000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
2500/5000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
3000/6000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
3000/6000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
5000/10000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
b) MRI, nuclear medicine, and other high-tech services		
1500/3000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
1500/3000/70%	30% coinsurance after deductible.	50% coinsurance after deductible.
2500/5000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
2500/5000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
3000/6000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
3000/6000/80%	20% coinsurance after deductible.	40% coinsurance after deductible.
5000/10000/100%	No coinsurance after deductible.	30% coinsurance after deductible.
15. EMERGENCY CARE[7, 8]		
1500/3000/100%	No coinsurance after deductible.	No coinsurance after deductible.
1500/3000/70%	30% coinsurance after deductible.	30% coinsurance after deductible.
2500/5000/100%	No coinsurance after deductible.	No coinsurance after deductible.
2500/5000/80%	20% coinsurance after deductible.	20% coinsurance after deductible.
3000/6000/100%	No coinsurance after deductible.	No coinsurance after deductible.
3000/6000/80%	20% coinsurance after deductible.	20% coinsurance after deductible.
5000/10000/100%	No coinsurance after deductible.	No coinsurance after deductible.
16. AMBULANCE		
a) Ground		
1500/3000/100%	No coinsurance after deductible.	No coinsurance after deductible.
1500/3000/70%	30% coinsurance after deductible.	30% coinsurance after deductible.
2500/5000/100%	No coinsurance after deductible.	No coinsurance after deductible.
2500/5000/80%	20% coinsurance after deductible.	20% coinsurance after deductible.
3000/6000/100%	No coinsurance after deductible.	No coinsurance after deductible.
3000/6000/80%	20% coinsurance after deductible.	20% coinsurance after deductible.
5000/10000/100%	No coinsurance after deductible.	No coinsurance after deductible.
b) Air		
1500/3000/100%	No coinsurance after deductible.	No coinsurance after deductible.
1500/3000/70%	30% coinsurance after deductible.	30% coinsurance after deductible.
2500/5000/100%	No coinsurance after deductible.	No coinsurance after deductible.
2500/5000/80%	20% coinsurance after deductible.	20% coinsurance after deductible.
3000/6000/100%	No coinsurance after deductible.	No coinsurance after deductible.
3000/6000/80%	20% coinsurance after deductible.	20% coinsurance after deductible.
5000/10000/100%	No coinsurance after deductible.	No coinsurance after deductible.

	IN-NETWORK	OUT-OF-NETWORK
17. URGENT, NON-ROUTINE, AFTER HOURS CARE 1500/3000/100% 1500/3000/70% 2500/5000/100% 2500/5000/80% 3000/6000/100% 3000/6000/80% 5000/10000/100%	No coinsurance after deductible. 30% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible.	30% coinsurance after deductible. 50% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible.
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. 0THER MENTAL HEALTH CARE a) Inpatient care 1500/3000/100% 1500/3000/70% 2500/5000/100% 2500/5000/80% 3000/6000/100% 3000/6000/80% 5000/10000/100% b) Outpatient care 1500/3000/100% 1500/3000/70% 2500/5000/100% 2500/5000/80% 3000/6000/100% 3000/6000/80% 5000/10000/100%	No coinsurance after deductible. 30% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. Limited to 45 full or 90 partial days per member in each benefit year in- and out-of-network combined. No coinsurance after deductible. 30% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. Up to a maximum of $500 per member in each benefit year in- and out-of-network combined. Maximum Anthem benefit for inpatient and outpatient care is limited to $10,000 per member per lifetime.	30% coinsurance after deductible. 50% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. Limited to 45 full or 90 partial days per member in each benefit year in- and out-of-network combined. 30% coinsurance after deductible. 50% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. Up to a maximum of $500 per member in each benefit year in- and out-of-network combined. Maximum Anthem benefit for inpatient and outpatient care is limited to $10,000 per member per lifetime.
20. ALCOHOL & SUBSTANCE ABUSE	Not covered	Not covered

	IN-NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY a) Inpatient	Covered d for inpatient rehabilitation therapy for up to 30 days per member in each benefit year in- and out-of-network combined.	Covered for inpatient rehabilitation therapy for up to 30 days per member in each benefit year in- and out-of-network combined.
b) Outpatient 1500/3000/100% 1500/3000/70% 2500/5000/100% 2500/5000/80% 3000/6000/100% 3000/6000/80% 5000/10000/100%	No coinsurance after deductible. 30% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. Speech therapy is limited to 60 visits per member in each benefit year in- and out-of-network combined, except for children to age 5.	30% coinsurance after deductible. 50% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. Speech therapy is limited to 60 visits per member in each benefit year in- and out-of-network combined, except for children to age 5.
22. DURABLE MEDICAL EQUIPMENT 1500/3000/100% 1500/3000/70% 2500/5000/100% 2500/5000/80% 3000/6000/100% 3000/6000/80% 5000/10000/100%	No coinsurance after deductible. 30% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. For prosthetic devices (arms and legs), benefits are provided with the same deductible and coinsurance as provided by Medicare.	30% coinsurance after deductible. 50% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. For prosthetic devices (arms and legs), benefits are provided with the same deductible and coinsurance as provided by Medicare.
23. OXYGEN 1500/3000/100% 1500/3000/70% 2500/5000/100% 2500/5000/80% 3000/6000/100% 3000/6000/80% 5000/10000/100%	No coinsurance after deductible. 30% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible.	30% coinsurance after deductible. 50% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible.
24. ORGAN TRANSPLANTS 1500/3000/100% 1500/3000/70% 2500/5000/100% 2500/5000/80% 3000/6000/100% 3000/6000/80% 5000/10000/100%	No coinsurance after deductible 30% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. Benefits limited to $1,000,000 lifetime maximum Anthem benefit per transplant.	30% coinsurance after deductible. 50% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. Benefits limited to $1,000,000 lifetime maximum Anthem benefit per transplant.

	IN-NETWORK	OUT-OF-NETWORK
25. HOME HEALTH CARE 1500/3000/100% 1500/3000/70% 2500/5000/100% 2500/5000/80% 3000/6000/100% 3000/6000/80% 5000/10000/100%	 No coinsurance after deductible. 30% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. Limited to 60 visits per member in each benefit year, in- and out-of-network combined.	 30% coinsurance after deductible. 50% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. Limited to 60 visits per member in each benefit year, in- and out-of-network combined
26. HOSPICE CARE a) Inpatient Care 1500/3000/100% 1500/3000/70% 2500/5000/100% 2500/5000/80% 3000/6000/100% 3000/6000/80% 5000/10000/100% b) Outpatient care 1500/3000/100% 1500/3000/70% 2500/5000/100% 2500/5000/80% 3000/6000/100% 3000/6000/80% 5000/10000/100%	 No coinsurance after deductible. 30% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. No coinsurance after deductible. 30% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible.	 30% coinsurance after deductible. 50% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. 30% coinsurance after deductible. 50% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible. 40% coinsurance after deductible. 30% coinsurance after deductible.
27. SKILLED NURSING FACILITY CARE	Not covered	Not covered
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Not covered	Not covered
30. CHIROPRACTIC CARE 1500/3000/100% 1500/3000/70% 2500/5000/100% 2500/5000/80% 3000/6000/100% 3000/6000/80% 5000/10000/100%	 No coinsurance after deductible. 30% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. Limited to 12 visits per member in each benefit year combined with acupuncture care (see line 31).	 Not covered Not covered Not covered Not covered Not covered Not covered Not covered

	IN-NETWORK	OUT-OF-NETWORK
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) 1500/3000/100% 1500/3000/70% 2500/5000/100% 2500/5000/80% 3000/6000/100% 3000/6000/80% 5000/10000/100%	Acupuncture care: No coinsurance after deductible. 30% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible. 20% coinsurance after deductible. No coinsurance after deductible Limited to 12 visits per member in each benefit year combined with chiropractic care (see line 30). $500 additional accident benefits per member per accident in allowed charges. Members who desire another professional opinion may obtain a second surgical opinion.	 Not covered Not covered Not covered Not covered Not covered Not covered Not covered $500 additional accident benefits per member per accident in allowed charges. 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 Personal Health Coach Program • Graduate from 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, 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"?	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?	(888) 224-4911	
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 1580 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 #'06-00341, 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.

[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. With our BluePreferred for Individuals PPO Plan, laboratory services for a Pap test are limited to a maximum payment of $75.00. With our Colorado HSA-Qualified Plans for Individuals, all services related to a Pap test are subject to the maximum benefit as described on the Health Benefit Plan Description Form. Under most plans pap tests received out of-network are not covered.

Mammogram Screenings

All plans except our HMO and PPO Basic Health and BluePreferred for Individual Plans provide mammogram screening coverage for women 35 years of age and older. 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. Our HMO and PPO Basic Health Plans do not provide coverage for mammogram screenings.

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. Our HMO and PPO Basic Health Plans do not provide coverage for prostate cancer screenings.

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. Under most plans colorectal cancer screenings received out of-network are not covered.

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.