Anthem BlueCross BlueShield

Schedule of Benefits (Who Pays What)

Anthem Blue Cross and Blue Shield

Name of Carrier

BluePreferred for Group Plan 3 EPO National Formulary

Name of Plan

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Only for Emergency and Urgent 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. Coverage for benefits shall meet or exceed those required by applicable law, which may change from time to time. 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 Precertification, prior authorization, a referral from your Primary Care Provider, 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]		
a) Individual[2b]	No Deductible	Not Covered
b) Family[2c]	No Deductible	Not Covered

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Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling member services at the number on the back of your Health Benefit ID Card.

	IN-NETWORK	OUT-OF-NETWORK
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] **a) Individual** **b) Family** **c) Is deductible included in the out-of-pocket maximum?**	 $5,000 Copayments, Deductible and Coinsurance are included in the Out-of-Pocket Annual Maximum. $10,000 Copayments, Deductible and Coinsurance are included in the Out-of-Pocket Annual Maximum. One Member may not contribute any more than the individual Out-of-Pocket Annual Maximum towards the family Out-of-Pocket Annual Maximum. Yes Some Covered Services have a maximum benefit of days, visits or dollar amounts allowed. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied.	 Not Covered Not Covered
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum for most Covered Services. Bariatric surgery has a per occurrence maximum benefit of $7,500 per Member for services received from a designated facility; total per occurrence maximum benefit shall not exceed $7,500 per Member from designated facilities and non-designated In Network facilities combined.	No lifetime maximum for most Covered Services. Bariatric surgery has a per occurrence maximum benefit of $1,500 per Member for services received from a facility that is not a designated facility; total per occurrence maximum benefit shall not exceed $7,500 per Member from designated facilities and non-designated In Network facilities combined.
7A. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO Provider network. See Provider directory for complete list of current Providers.	Not Covered
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my Primary Care Provider?	Yes	Not Covered

	IN-NETWORK	OUT-OF-NETWORK
8. MEDICAL OFFICE VISITS[4]		
a) Primary Care Providers	$40 Copayment per office visit. Includes non-laboratory and non-x-ray services. For laboratory and x-ray services see line 14 for payment information.	Not Covered
b) Specialists	$60 Copayment per office visit. Includes non-laboratory and non-x-ray services. For laboratory and x-ray services see line 14 for payment information.	Not Covered
9. PREVENTIVE CARE		
a) Children's services	No Copayment (100% covered)	Not Covered
b) Adult's services	No Copayment (100% covered)	Not Covered
10. MATERNITY		
a) Prenatal care	$40 Copayment for Primary Care Provider or $40 Copayment for Specialist for first prenatal care office visit/delivery from the Doctor. Includes non-laboratory and non-x-ray services. For laboratory and x-ray services see line 14 for payment information.	Not Covered
b) Delivery & inpatient well baby care[5]	$1,500 per admission Copayment.	Not Covered
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions[6]	**Inpatient Care** - Included with the inpatient Hospital benefit (see line 12). **Outpatient Care Retail Pharmacy** - Tier 1 $15 Copayment, tier 2 $50 Copayment, tier 3 $75 Copayment, tier 4 30% Copayment, per prescription up to a 30-day supply. For tier 4 Retail Pharmacy Drugs, the maximum Copayment per prescription is $250 per 30-day supply. **Outpatient Care Specialty Pharmacy** - Tier 1 $15 Copayment, tier 2 $50 Copayment, tier 3 $75 Copayment, tier 4 30% Copayment, per prescription up to a 30-day supply. For tier 4 Specialty Pharmacy Drugs the maximum Copayment per prescription is $250 per 30-day supply. Certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or	**Inpatient Care** - Included with the inpatient Hospital benefit (see line 12). **Outpatient Care Retail Pharmacy Drugs** - Not covered **Outpatient Care Specialty Pharmacy Drugs -** Not covered

	IN-NETWORK	OUT-OF-NETWORK
	through the Home Delivery (Mail Order) Pharmacy. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayment you pay for a 30-day supply at a Retail Pharmacy. **Outpatient Care Home Delivery Pharmacy** - Tier 1 $30 Copayment, tier 2 $100 Copayment, tier 3 $150 Copayment, per prescription up to a 90-day supply. Specialty pharmacy drugs are not available through the Home Delivery Pharmacy. **Preventive Rx Plus** - $5 Copayment, no deductible Prescription Drugs will always be dispensed as ordered by your Provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket expenses. You may request, or your Provider may order, the Brand Name Drug. However, if a Generic Drug is available, you will be responsible for the cost difference between the Generic and Brand Name Drug, in addition to your Generic Copayment. The cost difference between the Generic and Brand Name Drug does not go towards your Deductible or Out-of-Pocket Annual Maximum. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. For certain higher cost Generic Drugs, We keep the right, at Our sole discretion, to make an exception and not require you to pay the difference in the cost between Generic and the Brand Name Drug.	**Outpatient Care Home Delivery Pharmacy Drugs -** Not covered
12. INPATIENT HOSPITAL	$1,500 per admission Copayment.	Not Covered
13. OUTPATIENT / AMBULATORY SURGERY AT A FACILITY	$750 Copayment per admission	Not Covered

	IN-NETWORK	OUT-OF-NETWORK
14. DIAGNOSTICS **a) Laboratory & x-ray**	$40 Copayment for laboratory and x-ray services	Not Covered
b) MRI, nuclear medicine, and other high-tech services	$200 Copayment per procedure for MRI or CT Scans $400 Copayment per procedure for PET scan and other High Tech Services	Not Covered
15. EMERGENCY CARE[7]	**$350 Copayment per emergency room visit.** Copayment is waived if admitted.	Out-of-Network care is paid as In-Network
16. AMBULANCE	You pay $350 Copayment per trip for Ambulance.	Out-of-Network care is paid as In-Network
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$70 Copayment per visit. Includes non-laboratory and non-x-ray services. For laboratory and x-ray services see line 14 for payment information.	Out-of-Network care is paid as In-Network
18. MENTAL HEALTH CARE **a) Inpatient care**	$1,500 per admission Copayment.	Not Covered
b) Outpatient care	For outpatient facility services, you pay no copayment, for outpatient office visits and professional services, you pay $40 Copayment per visit. Mental health care includes without limitation, biologically based mental illness, care that has a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition.	Not Covered
19. ALCOHOL & SUBSTANCE ABUSE	**Inpatient Care** - $1,500 per admission Copayment. **Outpatient Care** - For outpatient facility services, you pay no copayment, for outpatient office visits and professional services, you pay $40 Copayment per visit.	Not Covered Not Covered

	IN-NETWORK	OUT-OF-NETWORK
20. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	**Inpatient Care** - Included with the inpatient Hospital Copayment (see line 12). Up to 30 inpatient rehab days per calendar year **Outpatient Care** - $40 Copayment per visit. Includes non-laboratory and non-x-ray services. For laboratory and x-ray services see line 14 for payment information. Up to 20 visits each for physical, occupational and speech therapy per calendar year. From birth until the Your sixth birthday, benefits are provided as required by applicable law.	Not Covered Not Covered
21. DURABLE MEDICAL EQUIPMENT	No Copayment, 100% covered	Not covered
22. OXYGEN	No Copayment, 100% covered	Not covered
23. ORGAN TRANSPLANTS	**Inpatient Care** - $1,500 per admission Copayment **Outpatient Care** - $40 Copayment for Primary Care Provider or $60 Copayment per office visit for services from a Specialist. Includes non-laboratory and non-x-ray services. For laboratory and x-ray services see line 14 for payment information. Transportation and lodging services are limited to a maximum benefit of $10,000 per Transplant Benefit Period; unrelated donor searches are limited to a maximum benefit of $30,000 per Transplant Benefit Period.	**Inpatient Care** - Not covered **Outpatient Care** - Not covered
24. HOME HEALTH CARE	$40 Copayment per visit. Includes laboratory and non-x-ray services. For laboratory and x-ray services see line 14 for payment information. Up to 100 visits per calendar year.	Not covered
25. HOSPICE CARE	**Inpatient Care** - You pay no Coinsurance (100% covered) **Outpatient Care** - You pay no Coinsurance (100% covered)	Not Covered Not Covered

	IN-NETWORK	OUT-OF-NETWORK
26. SKILLED NURSING FACILITY CARE	$1,500 per admission Copayment. Up to 100 days per calendar year. Copayment is waived if admitted directly to Skilled Nursing Facility from an inpatient acute facility.	Not Covered
27. DENTAL CARE	Not covered	Not covered
28. VISION CARE	Not covered	Not covered
29. CHIROPRACTIC THERAPY	$40 Copayment per office visit. Includes non-laboratory and non-x-ray services. For laboratory and x-ray services see line 14 for payment information. Up to 20 visits per calendar year, regardless of which type of Provider renders the therapy.	Not covered

30. SIGNIFICANT ADDITIONAL COVERED SERVICES	**Retail Health Clinic** $40 Copayment per office visit. Includes non-laboratory and non-x-ray services. For laboratory and x-ray services see line 14 for payment information. **Other Covered Services** • **Massage Therapy -** $40 Copayment per office visit. Includes non-laboratory and non-x-ray services. For laboratory and x-ray services see line 14 for payment information. Up to 20 visits per calendar year combined for massage and acupuncture therapy, regardless of which type of Provider renders the therapy. • **Acupuncture/Nerve Pathway Therapy -** $40 Copayment per office visit. Includes non-laboratory and non-x-ray services. For laboratory and x-ray services see line 14 for payment information. Up to 20 visits per calendar year combined for massage and acupuncture therapy, regardless of which type of Provider renders the therapy. • **Nutritional Counseling (other than for eating disorders and Diabetes Management) -** $40 Copayment per visit for Specialist. Includes non-laboratory and non-x-ray services. For laboratory and x-ray services see line 14 for payment information. Up to 4 visits per calendar year. • **Nutritional Counseling for eating disorders** - Covered under Mental Health Care, please see row 19. • **Nutritional Counseling for Diabetes Management** - Benefit level determined by place of service. **Hearing Aids** Benefit level determined by place of service. Hearing aids are covered up to age 18. Initial and replacement hearing aids will be supplied every 5 years. New hearing aid will be a covered service when alterations to your existing hearing aid cannot adequately meet your needs or be repaired.	**Retail Health Clinic** Not covered **Other Covered Services** • **Massage Therapy -** Not covered • **Acupuncture/Nerve Pathway Therapy -** Not covered • **Nutritional Counseling (other than for eating disorders and Diabetes Management) -** Not covered • **Nutritional Counseling for eating disorders** – Not Covered • **Nutritional Counseling for Diabetes Management** – not Covered. Not Covered Not Covered

	IN-NETWORK	OUT-OF-NETWORK
	Applied Behavioral Analysis Services Benefits are based on the setting in which Covered Services are received. **General Information** For outpatient Covered Service not elsewhere listed, you pay Coinsurance. For example this includes chemotherapy, radiation therapy or dialysis. However, some outpatient Covered services received from a Hospital may require a Copayment prior to and in addition to the Coinsurance.	

PART C: LIMITATIONS AND EXCLUSIONS

31. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.	Not applicable; plan does not impose limitation periods for pre-existing conditions.
32. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
33. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable; plan does not exclude coverage for pre-existing conditions.
34. 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
35. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Not Covered
36. Is Precertification required for surgical procedures and hospital care (except in an emergency)?	Yes, the Doctor who schedules the procedure or Hospital care is responsible for obtaining the Precertification.	Not Covered
37. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Not Covered
38. What is the main member service number?	877-811-3106	
39. Whom do I write/call if I have a complaint or want to file a grievance?	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273 877-811-3106	
40. 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	
41. 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 COLGPPONGF Large Group	
42. 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 30.

[2b] "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for the 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., "$3,000 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.

[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 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.

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 under the preventive care benefits for a routine annual Pap test and the related office visit. Payment for the routine Pap test is based on the plan's provisions for preventive care. Payment for the related office visit is based on the plan's preventive care provisions.

Mammogram Screenings

All plans provide coverage under the preventive care benefits for routine screening or diagnostic mammogram regardless of age. Payment for the mammogram screening benefit is based on the plan's provisions for preventive care.

Prostate Cancer Screenings

All plans provide coverage under the preventive care benefits for routine prostate cancer screening for men. Payment for the prostate cancer screening is based on the plan's provisions for preventive care.

Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All plans provide coverage for routine colorectal cancer screenings, such as fecal occult blood tests, barium enema, sigmoidoscopies and colonoscopies. Depending on the type of colorectal cancer screening received, payment for the benefit is based on where the services are rendered and if rendered as a screening or medical procedure. Colorectal cancer screenings are covered under preventive care as long as the services provided are for a preventive screening. Payment for preventive colorectal cancer screenings is based on the plan's provisions for preventive care.

NOTICE OF
PROTECTION PROVIDED BY
LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

This notice provides a **brief summary** of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website www.colifega.org, email jwrhodesifega.org or contact:

Colorado Life and Health Insurance Protection Association 201 Robert S. Kerr Ave. Suite 600 Oklahoma City, OK 73102 1-800-337-7796	*Colorado Division of Insurance* 1560 Broadway, Suite 850 Denver, CO 80202 (303) 894-7499

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.