

**Schedule of Benefits (Who Pays What)
Anthem Blue Cross and Blue Shield**

Name of Carrier

Health Savings Account (HSA-Compatible) PPO Plan 2 National Formulary

Name of Plan

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. 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 TYPE²	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE^{2a}		
a) Individual^{2b}	\$3,000	\$3,000
b) Family^{2c}	\$6,000, aggregate	\$6,000, aggregate
	<p>If you select family membership when one family Member has satisfied their individual Deductible, that family Member is eligible for benefits. The enrolled remaining family Members are eligible for benefits when they individually satisfy their individual Deductible or collectively satisfy the balance of the family Deductible. When no family Member meets the individual Deductible, but the family Members collectively meet the entire family Deductible, then all family Members will be eligible for benefits. The In-Network Deductible cannot be applied toward meeting the Out-Network Deductible.</p>	<p>If you select family membership when one family Member has satisfied their individual Deductible, that family Member is eligible for benefits. The enrolled remaining family Members are eligible for benefits when they individually satisfy their individual Deductible or collectively satisfy the balance of the family Deductible. When no family Member meets the individual Deductible, but the family Members collectively meet the entire family Deductible, then all family Members will be eligible for benefits. The Out-Network Deductible cannot be applied toward meeting the In-Network Deductible.</p>

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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
	<p>maximum benefit of days, visits or dollar amounts allowed. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied.</p> <p>Copayments for Prescription Drugs are included in the Out-of-Pocket Annual Maximum.</p>	<p>maximum benefit of days, visits or dollar amounts allowed. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied. The difference between Billed Charges and the Maximum Allowed Amount for Non-Participating Providers does not count toward the Out-of-Pocket Annual Maximum. Even once the Out-of-Pocket Annual Maximum is satisfied, you will still be responsible for paying the difference between the Maximum Allowed Amount and the Non-Participating Providers Billed Charges (sometimes called “balance billing”).</p> <p>The amounts you pay for Out-of-Network Covered Services are in addition to your balance billing costs.</p>
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.	All Providers licensed or certified to provide Covered Services.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my Primary Care Provider?	Yes	Yes
8. MEDICAL OFFICE VISITS⁴		
a) Primary Care Providers	You pay 20% Coinsurance after Deductible.	You pay 30% after Deductible
b) Specialists	You pay 20% Coinsurance after Deductible.	You pay 30% after Deductible
9. PREVENTIVE CARE		
a) Children services	You pay no Coinsurance (100% covered), not subject to Deductible.	You pay 30% after Deductible
b) Adult services	You pay no Coinsurance (100% covered), not subject to Deductible.	You pay 30% after Deductible

	IN-NETWORK	OUT-OF-NETWORK
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care ⁵	You pay 20% Coinsurance after Deductible. You pay 20% Coinsurance after Deductible.	You pay 30% after Deductible You pay 30% after Deductible
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions⁶ National Formulary	<p>Inpatient care - Included with the inpatient Hospital benefit (see line 12).</p> <p>After the Deductible is satisfied, the following Copayments apply until the annual Out-of-Pocket Annual Maximum is satisfied. These Copayments accumulate toward the Out-of-Pocket Annual Maximum. Once the full Out-of-Pocket Annual Maximum is satisfied, then you pay no further Copayments for that calendar year.</p> <p>Outpatient Care Retail Pharmacy - tier 1 \$15 Copayment, tier 2 \$50 Copayment, tier 3 \$75 Copayment, tier 4 30% Copayment, after Deductible 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.</p> <p>Outpatient care Specialty Pharmacy - tier 1 \$15 Copayment, tier 2 \$50 Copayment, tier 3 \$75 Copayment, tier 4 30% Copayment, after Deductible 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 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.</p> <p>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</p>	<p>Inpatient care - Included with the inpatient Hospital benefit (see line 12).</p> <p>Outpatient Care Retail Pharmacy - You pay 30% after Deductible for up to a 30 day supply.</p> <p>Outpatient Care Specialty Pharmacy - Not covered</p> <p>Outpatient care Home Delivery</p>

	IN-NETWORK	OUT-OF-NETWORK
	<p>Home Delivery Pharmacy.</p> <p>Preventive Rx Plus - \$5 Copayment, no deductible</p> <p>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.</p>	Pharmacy - Not covered
12. INPATIENT HOSPITAL	You pay 20% Coinsurance after Deductible.	You pay 30% after Deductible.
13. OUTPATIENT / AMBULATORY SURGERY AT A FACILITY	You pay 20% Coinsurance after Deductible.	You pay 30% after Deductible.
14. DIAGNOSTICS		
a) Laboratory & x-ray	You pay 20% Coinsurance after Deductible	You pay 30% after Deductible.
b) MRI, nuclear medicine, and other high-tech services	You pay 20% Coinsurance after Deductible	You pay 30% after Deductible.
15. EMERGENCY CARE⁷	You pay 20% Coinsurance after Deductible.	Out-of-Network care is paid as In-Network.
16. AMBULANCE	You pay 20% Coinsurance after Deductible.	Out-of-Network care is paid as In-Network; non-emergency ambulance services will be limited to a maximum benefit of \$50,000 per occurrence.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	You pay 20% Coinsurance after Deductible.	You pay 30% after Deductible.
18. MENTAL HEALTH CARE		
a) Inpatient care	You pay 20% Coinsurance after Deductible.	You pay 30% after Deductible
b) Outpatient care	You pay 20% Coinsurance after	You pay 30% after Deductible

	IN-NETWORK	OUT-OF-NETWORK
	Deductible.	
19. ALCOHOL & SUBSTANCE ABUSE	<p>Inpatient Care - You pay 20% Coinsurance after Deductible.</p> <p>Outpatient Care - You pay 20% Coinsurance after Deductible.</p>	<p>Inpatient Care - You pay 30% after Deductible.</p> <p>Outpatient Care - You pay 30% after Deductible.</p>
20. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	<p>Inpatient Care - Included with inpatient Hospital benefit (see line 12). Up to 30 inpatient rehab days per calendar year In and Out-of-Network combined.</p> <p>Outpatient Care - You pay 20% Coinsurance after Deductible. Up to 20 visits each for physical, occupational and speech therapy per calendar year In and Out-of-Network combined. From birth until the Your sixth birthday benefits are provided as required by applicable law.</p>	<p>Inpatient Care - Included with inpatient hospital benefit (see line 12). Up to 30 inpatient rehab days per calendar year In and Out-of-Network combined.</p> <p>Outpatient Care - You pay 30% after Deductible. Up to 20 visits each for physical, occupational and speech therapy per calendar year In and Out-of-Network combined. From birth until the Your sixth birthday, benefits are provided as required by applicable law.</p>
21. DURABLE MEDICAL EQUIPMENT	You pay 20% Coinsurance after Deductible. Wigs for alopecia resulting from chemotherapy and radiation therapy up to a maximum benefit by Anthem of \$500 per Member per calendar year.	Not covered
22. OXYGEN	You pay 20% Coinsurance after Deductible.	Not covered
23. ORGAN TRANSPLANTS	<p>You pay 20% Coinsurance after Deductible.</p> <p>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.</p>	Not covered
24. HOME HEALTH CARE	You pay 20% Coinsurance after Deductible. Up to 100 visits per calendar year.	Not covered
25. HOSPICE CARE	You pay 20% Coinsurance after Deductible.	You pay 30% after Deductible.
26. SKILLED NURSING FACILITY CARE	You pay 20% Coinsurance after Deductible. Up to 100 days per calendar year In and Out-of-Network combined.	You pay 30% after Deductible. Up to 100 days per calendar year In and Out-of-Network combined.
27. DENTAL CARE	Not covered	Not covered
28. VISION CARE	Not covered	Not covered
29. CHIROPRACTIC THERAPY	You pay 20% Coinsurance after Deductible. Up to 20 visits per	Not covered

	IN-NETWORK	OUT-OF-NETWORK
	calendar year, regardless of which type of Provider renders the therapy.	
30. SIGNIFICANT ADDITIONAL COVERED SERVICES	<p>Retail Health Clinic You pay 20% Coinsurance after Deductible.</p> <p>Other Covered Services Massage Therapy - You pay 20% Coinsurance after Deductible. Up to 20 visits per calendar year combined for massage and acupuncture therapy, regardless of which type of Provider renders the therapy.</p> <p>Acupuncture/Nerve Pathway Therapy - You pay 20% Coinsurance after Deductible. Up to 20 visits per calendar year combined for massage and acupuncture therapy, regardless of which type of Provider renders the therapy.</p> <p>Nutritional Counseling (other than for eating disorders and Diabetes Management) - You pay 20% Coinsurance after Deductible. Up to 4 visits per calendar year.</p> <p>Nutritional Counseling for eating disorders – Covered under Mental Health care, please see row 19.</p> <p>Nutritional Counseling for Diabetes Management – Benefit level determined by place of service.</p> <p>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.</p> <p>New hearing aid will be a covered service when alterations to your existing hearing aid cannot adequately meet your needs or be repaired.</p> <p>Applied Behavioral Analysis Services Benefits are based on the setting in which Covered Services are received.</p>	<p>Retail Health Clinic Not covered</p> <p>Other Covered Services Massage Therapy - Not covered</p> <p>Acupuncture/Nerve Pathway Therapy - Not covered</p> <p>Nutritional Counseling (other than for eating disorders and Diabetes Management) - Not covered</p> <p>Nutritional Counseling for eating disorders – Covered under Mental Health care, please see row 19.</p> <p>Nutritional Counseling for Diabetes Management – Benefit level determined by place of service.</p> <p>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.</p> <p>New hearing aid will be a covered service when alterations to your existing hearing aid cannot adequately meet your needs or be repaired.</p> <p>Applied Behavioral Analysis Services Benefits are based on the setting in which Covered Services are received.</p>

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	No
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.	Yes, you are responsible for obtaining Precertification.
37. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, you will be responsible for paying the difference between the Maximum Allowed Amount and the Non-Participating Provider's Billed Charges (sometimes called "balance billing"). The amounts you pay for Out-of-Network Covered Services are in addition to your balance billing costs.
38. What is the main member service number?	866-837-4596	
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 866-837-4596	
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 # COLGCDHPNGF 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 jwrhodes@colifega.org or contact:

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