



An Anthem Company

Colorado Health Plan Description Form

HMO Colorado

BlueAdvantage HMO Plan No. 20-700

Prescription Drugs 15/40/60

With Chiropractic, Alcohol and Substance Abuse Rehabilitation Care

Effective July 1, 2007

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Health maintenance organization (HMO)
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. 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 ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4. ANNUAL DEDUCTIBLE ² a) Individual	No deductible
b) Family	No deductible
5. OUT-OF-POCKET ANNUAL MAXIMUM ³ a) Individual	\$2,000
b) Family	\$4,000 Once you and/or your family have satisfied the out-of-pocket annual maximum for inpatient hospital facility services, outpatient hospital/alternative care facility services (except MRI, CT, PET scans, therapy services or rehabilitation services), no additional copayments shall be required from you and/or your family for the remainder of the contract year for those services. All other copayments including but not limited to PCP copayment, specialist's copayments, or prescription drug copayments do not apply to the out-of-pocket annual maximum and are still required after the out-of-pocket annual maximum is met.
c) Is deductible included in the out-of-pocket maximum?	No
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum for most covered services. Infertility services have a lifetime maximum of \$2,000 per member. Morbid obesity surgery has a lifetime maximum payment of \$15,000 per member from a facility that has been designated as a Center of Excellence or \$1,500 from a facility that has not been designated as a Center of Excellence with a total lifetime maximum that shall not exceed \$15,000 per member. Major organ transplants have a lifetime maximum of \$1,000,000 per transplant per member.
7A. COVERED PROVIDERS	HMO Colorado managed care network. See provider directory for complete list of current providers.

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes
8. ROUTINE MEDICAL OFFICE VISITS ⁴ a) Primary Care Providers b) Specialists	\$20 copayment per visit for PCP \$40 copayment per visit for specialist
9. PREVENTIVE CARE a) Children's services b) Adults' services	\$20 copayment per visit for PCP \$40 copayment per visit for specialist \$20 copayment per visit for PCP \$40 copayment per visit for specialist
10. MATERNITY a) Prenatal care b) Delivery & inpatient well baby care ⁵	\$40 copayment for first prenatal care visit \$700 copayment per admission
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions ⁶ a) Inpatient care b) Outpatient care c) Prescription Mail Service	Included with inpatient hospital copayment (see line 12) Retail Pharmacy Drugs - Tier 1 \$15 copayment, tier 2 \$40 copayment, tier 3 \$60 copayment, per prescription at a participating pharmacy up to a 30-day supply. Specialty Pharmacy Drugs - Tier 1 \$15 copayment, tier 2 \$40 copayment, tier 3 \$60 copayment, per prescription from our Specialty Pharmacy up to a 90-day supply. Specialty Pharmacy Drugs are not available at a retail pharmacy or from a mail-order pharmacy. Mail-Order Pharmacy Drugs - Tier 1 \$30 copayment, tier 2 \$80 copayment, tier 3 \$120 copayment, per prescription through the mail-order service up to a 90-day supply. Specialty pharmacy drugs are not available through the mail-order service. The following applies to b) and c) above: Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem, up to \$250 per member per contract year, \$500 per lifetime. In addition to the cost sharing described above, if you purchase a tier-2 or tier-3 prescription drug when there is a FDA rated equivalent tier-1 drug available, you are responsible for the tier-2 or tier-3 copayment for the prescription drug and you will pay the difference between the cost of the prescription drug and the cost of the tier-2 or tier-3 prescription drug. For example: a Tier-2 prescription costs \$50; a tier-1 substitution is available, the tier-1 prescription costs \$20, you pay the \$30 difference plus the tier-copayment not to exceed the negotiated rate of the drug. The \$30 difference is not applied towards any other cost-sharing requirement. For drugs on our approved list, call customer service at 877-811-3106.
12. INPATIENT HOSPITAL	\$700 copayment per admission
13. OUTPATIENT/AMBULATORY SURGERY	\$325 copayment per surgery

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, and other high-tech services	No copayment (100% covered) \$100 copayment per procedure for MRI/MRA/CT/PET scans
15. EMERGENCY CARE ^{7,8}	\$150 copayment per emergency room visit. Copayment is waived if admitted. Care is covered in- or out-of-network.
16. AMBULANCE	\$50 copayment per trip for ground or air ambulance. Copayment is waived if admitted.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	\$40 copayment per urgent care visit. Urgent care may be received from your PCP or from an urgent care center. Care is covered in- or out-of-network.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE ⁹	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	Covered person pays 50% of allowed amount. Limited to 45 full or 90 partial days per contract year. \$20 copayment per visit. Limited to 20 visits per contract year.
20. ALCOHOL & SUBSTANCE ABUSE	Treatment: Covered person pays 50% of allowed amount (covered only for short term detoxification) Rehabilitation: Inpatient – Covered person pays 50% of allowed amount (limited to 45 full or 90 partial days per contract year combined with other mental health care (line 19) with a maximum of two admissions per lifetime). Outpatient - \$40 copayment per visit. Limited to 20 visits per contract year.
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY a) Inpatient b) Outpatient	\$700 copayment per admission. Limited to 30 non-acute inpatient days per contract year. \$20 copayment per visit for PCP \$40 copayment per visit for specialist Limited to 20 visits per contract year each for physical, occupational and speech therapy.
22. DURABLE MEDICAL EQUIPMENT	No copayment (100% covered). Limited to a maximum payment of \$1,000 per contract year combined with oxygen (see line 23) except for prosthetic devices which are not subject to the maximum payment but do reduce the maximum payment of \$1,000.
23. OXYGEN	No copayment (100% covered). Limited to a maximum payment of \$1,000 per contract year combined with durable medical equipment (see line 22).
24. ORGAN TRANSPLANTS a) Major Organ Transplant Inpatient Outpatient b) Other Transplants Inpatient Outpatient	\$700 copayment per admission \$20 copayment per visit for PCP \$40 copayment per visit for specialist \$700 copayment per admission \$20 copayment per visit for PCP \$40 copayment per visit for specialist Benefits are limited to \$1,000,000 payment per transplant with a maximum payment of \$10,000 for transportation and lodging and maximum payment of \$25,000 for donor services.
25. HOME HEALTH CARE	No copayment (100% covered)
26. HOSPICE CARE	No copayment (100% covered)
27. SKILLED NURSING FACILITY CARE	No copayment (100% covered). Limited to 60 days per contract year.
28. DENTAL CARE	Not covered

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
29. VISION CARE	Vision benefits included in this plan can be found on the separate Anthem Vision Summary Description.
30. CHIROPRACTIC CARE	\$20 copayment per visit. Limited to 20 visits per contract year.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Members who desire another professional opinion may obtain a second opinion. Osteopathic manipulative therapy (OMT) is limited to a maximum of 6 outpatient visits per calendar year.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. ¹⁰	Not applicable; plan does not impose limitation periods for pre-existing conditions.
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"?	Not applicable. Plan does not exclude coverage for pre-existing conditions.
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
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No
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 the pre-certification.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
39. What is the main customer service number?	303-831-0161 or toll free at 800-334-6557
40. Whom do I write/call if I have a complaint or want to file a grievance? ¹¹	HMO Colorado, Complaints and Appeals 700 Broadway Denver, CO 80273 303-831-0161 or toll free at 800-334-6557
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 #'s 98770_HMO Group – all sizes
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" 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) 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 may be noted in boxes 8 through 31.

³ “Out-of-pocket maximum” The maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductible or copayments, depending on the contract for that plan. 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 may be noted in boxes 8 through 31.

⁴ Routine 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 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 services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb threatening emergency existed.

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.

BLUEVIEW SUMMARY OF VISION BENEFITS

Anthem West – Exam Only Plan

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

Blue View Vision’s Provider Network: Blue View Vision members have access to approximately 32,500 conveniently located providers nationwide. Blue View Vision contracts with many providers, which including independent optometrists and ophthalmologists as well as well as LensCraftersSM, Target Optical and most Sears Optical and Pearle Vision retail locations. Members may call Blue View Vision toll-free at (866) 723-0515 or visit www.anthem.com at any time for provider locations.

For fast, paperless determination and confirmation of benefits, simply schedule an appointment with your *Blue View Vision* Provider and identify yourself as a *Blue View Vision* member.

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

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

Value Added Savings: *Blue View Vision* providers agree to the Additional Savings Plan that is significantly below retail. Members are able to achieve substantial savings on additional pair purchases, contact lenses, lens treatments, specialized lenses and various other items. Members may save approximately 15% to 40% off retail on these items when they visit a *Blue View Vision* Provider.

Copayment(s): Copayment amounts are applicable to Network Provider examinations. Plan allowances must be applied for a single service within a member’s benefit year; no remaining balance may be carried forward for another service within the benefit year.

BlueView Vision Benefits	Member Benefit from Network Provider	Non-Network Reimbursement
Vision Examination: Each member is entitled to a comprehensive vision examination by a Network Provider. This is a vision examination only and does not cover a separate contact lens professional fitting fee. Availability : Once every 12 months*	HMO: \$15.00 Copayment Point-of-Service: \$20.00 Copayment BluePreferred: \$25 Copayment	Up to \$35.00
Materials: Prescription lenses and frames	Available at Anthem Vision Preferred Prices	Not Covered
Contact Lenses:	Available at Anthem Vision Preferred Prices	Not Covered

* Benefits are available from the last date of service

Limitations and Exclusions:

This is a primary vision care benefit and is intended to cover an eye examination only. Materials and any items not covered may be purchased at Preferred Pricing from an Anthem Vision Provider. In addition, the examination is only payable while the group and member coverage is in force.

- Eyeglass Frames
- Eyeglass Lenses
- Elective or Non-Elective Contact Lenses
- Orthoptics or vision training and any supplemental testing.
- Plano (non-prescription) lenses.
- Medical or surgical treatment of the eyes.
- An eye exam or corrective eyewear required by an employer as a condition of employment.
- Any injury or illness covered under Workers’ Compensation or similar law, or which is work related.

- Sub-normal vision aids.
- Experimental or non-conventional treatments or devices.
- Safety eyewear.
- In conjunction with other offers or discounts.

An Anthem Company

Anthem Blue Cross and Blue Shield & HMO Colorado Health Plan Description Form Disclosure Amendment

Colorado law requires carriers to make available a Colorado Health 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.

Individual Health Plans

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.**

Group Health Plans

Pursuant to Colorado law (C.R.S. §10-16-105(5)(g)(I)), small employers purchasing any health benefit plan other than a Basic Health Benefit Plan, must pay for all benefits mandated by Colorado law, including nonwaivable coverages for: newborn, maternity, pregnancy, childbirth, complications from pregnancy and childbirth, therapies for congenital defects and birth abnormalities, low-dose mammography, mental illness, biologically-based mental illness, the availability of alcoholism treatment, the availability of hospice care, prostate cancer screening, child health supervision services, hospitalization and general anesthesia for dental procedures for dependent children, diabetes, and prosthetic devices.

Pursuant to Colorado law (C.R.S. §10-16-105(5)(g)(II)), small employers purchasing a Basic Health Benefit Plan is waiving coverage for low-dose mammography screening, mental illness, prostate cancer screening, hospitalization and general anesthesia for dental procedures for children, the availability of treatment for alcoholism, and the availability of hospice care. All other state-mandated benefits are included in the Basic Health Benefit Plan.

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 policyholder fails to comply with participation or contribution rules;**
- 4. The carrier elects to discontinue offering and non-renew all of its small group or large group plans delivered or issued for delivery in Colorado;**

5. An employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan;
6. With respect to group health benefit plans offered through a managed care plan, there are no longer any enrollees who live, reside or work in the service area; or
7. With respect to coverage of an employer that is made available only through one or more bona fide associations, the membership of an employer ceases.

Important Information for Employers with 50 or Fewer Employees and Business Groups of One: Rates are calculated based on allowable case characteristics – age bands, geographic location, family size, health status, and claims experience – and will be given within five working days of request. Rates for a specific employer cannot be adjusted due to the duration of coverage of employees or dependents of the small employer. Rates may change based on case characteristics, whenever benefits are changed, or upon giving written notice to the employer not less than 31 days prior to the effective date of the change. New applicants may be subject to pre-existing condition clauses, based on HIPAA requirements. Renewal of health insurance coverage in this class is guaranteed, assuming compliance with underwriting regulations. A Network Access Plan, which describes Anthem Blue Cross and Blue Shield’s or HMO Colorado’s network standards and evaluation procedures for ensuring provider access is available by calling our customer service department.

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS SPECIFIED BY LAW.

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 health of the people we serve. We cover cancer screenings as described below.

Pap Tests

All plans except our BasicBlue PPO Plan provide coverage for an annual Pap test and the related office visit. The BasicBlue PPO Plan provides coverage for a Pap test and the related office visit once every three years. 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 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. For BluePreferred for Individuals the following frequency guidelines apply: For women between the ages of 35 years and 40 years, a single baseline screening mammogram is covered. For women between 40 years of age and less than 50 years of age, a screening mammogram is covered once every two years, or it is covered annually if the member's physician has determined that identified breast cancer risk factors are present. For women between the ages of 50 years and 65 years, a screening mammogram is covered annually. 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. The following frequency guidelines apply: For men between 40 years of age and less than 50 years of age, a prostate cancer screening is covered annually if the member's physician has determined that identified prostate cancer risk factors are present. For men 50 years of age and older, a prostate cancer screening is covered annually. 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 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 Plan Description Form.