

**HMO Colorado/Anthem Blue Cross and Blue Shield
Colorado Higher Education Insurance Benefits Alliance Trust
Effective January 1, 2017**

PART A: TYPE OF COVERAGE

	Blue Advantage HMO/Point-of-Service (POS) Plan	PRIME Blue Priority PPO Plan	Blue Priority HMO Plan	Lumenos HDHP-PPO Plan
TYPE OF PLAN	Point of Service	Preferred Provider Plan	Health Maintenance Organization (HMO)	Preferred Provider Plan
OUT-OF-NETWORK CARE COVERED?¹	Yes, but patient pays more for out-of-network care.	Yes, but the patient pays more for out-of-network care	Only for Emergency and Urgent Care	Yes, but patient pays more for out-of-network care
AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado	Blue Priority Designated providers are available in Adams, Arapahoe, Boulder, Denver, Douglas, El Paso, Elbert, Fremont, Jefferson, La Plata, Montezuma, Pueblo, Summit and Teller counties. Participating Providers are available throughout Colorado.	Plan is available in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Elbert, Fremont, Jefferson, La Plata, Montezuma, Pueblo, Summit and Teller counties.	Plan is available throughout Colorado
Grandfathered Health Plan	No	No	No	No

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.

	Blue Advantage HMO/Point-of-Service (POS)		PRIME Blue Priority PPO Plan		Blue Priority HMO Plan	Lumenos HDHP-PPO Plan	
	In Network (HMO)	Out of Network (POS)	In Network	Out of Network	In Network Only (Out-of-Network care is not covered except as noted)	In Network	Out of Network
Deductible Type²	Calendar Year		Calendar Year		Calendar Year	Calendar Year	
ANNUAL DEDUCTIBLE^{2a}							
a) Individual (Single)^{2b}	No Deductible	\$500	\$400, excludes Copayments	\$1,000	\$2,000	\$2,500	\$2,500
b) Family^{2c} (Non-Single)	No Deductible	\$1,000	\$800, excludes Copayments	\$2,000	\$6,000	\$5,000	\$5,000
Some covered services have a maximum benefit of days, visits or dollar amounts. When the deductible is applied to a covered service which has a maximum number of days or visits, those maximum benefits will be reduced by the amount applied toward the deductible, whether or not the covered service is paid.			One Member may not contribute any more than the individual Deductible towards the family Deductible.		Plus separate \$200 Deductible per individual or \$400 per family for outpatient tier 2 and tier 3 Prescription Drugs. One Member may not contribute any more than the individual Deductible towards the family Deductible.	If you select non-single membership, no single Deductible applies and the non-single Deductible must be met before we reimburse for Covered Services. The non-single Deductible amount is met as follows: when one family Member has satisfied the non-single Deductible, that family Member and all other family Members are eligible for benefits. When no one family Member meets the non-single Deductible, but the family Members collectively meet the entire non-single Deductible, then all family Members will be eligible for benefits. The family Deductible is also applicable for newborn and adopted children (and for all other family Members) for the first 31-day period following birth or adoption if the child is enrolled or not enrolled.	
						The In-Network Deductible cannot be applied toward meeting the Out-Network Deductible.	The Out-Network Deductible cannot be applied toward meeting the In-Network Deductible.

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	BlueAdvantage HMO/Point-of-Service (POS)		PRIME Blue Priority PPO Plan		Blue Priority HMO Plan	Lumenos HDHP-PPO Plan	
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OUT-OF-POCKET ANNUAL MAXIMUM³							
a) Individual (Single)	\$2,000	\$3,000	\$2,000	\$4,000	\$4,000	\$2,500	\$5,000
b) Family (Non-Single)	\$4,000	\$6,000	\$4,000	\$8,000	\$10,000	\$5,000	\$10,000
			One Member may not contribute any more than the individual Out-of-Pocket Annual Maximum towards the family 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.		If you select Family (Non-single) membership, no single Out-of-Pocket Annual Maximum applies and the non-single Out-of-Pocket Annual Maximum must be met as follows: when one family (non-single) Member has satisfied the non-single Out-of-Pocket Annual Maximum, that non-single Member and all other family Members will be treated as having satisfied the Out-of-Pocket Annual Maximum. When no one family Member meets the non-single Out-of-Pocket Annual Maximum, but the family Members collectively meet the entire non-single Out-of-Pocket Annual Maximum, then all family Members will be treated as having satisfied the Out-of-Pocket Annual Maximum. The non-single Out-of-Pocket Annual Maximum is also applicable for newborn and adopted children (and for all other family Members) for the first 31-day period following birth or adoption if the child is enrolled or not enrolled.
c) What is included in the Out-of-Pocket Maximum? Some covered services have a maximum number of days, visits or dollar amounts allowed during a calendar year. 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, the member will still be responsible for paying the difference between the maximum allowed amount and the non-participating providers billed charges (sometimes called "balance billing"). The amounts you pay for Out-of-Network Covered Services are in addition to your balance billing costs.	All Copayments, including prescription drug copayments are included in the Out-of-Pocket Maximum.	Annual Deductible, Coinsurance and any Copayments are included in the Out-of-Pocket Maximum.	All copayments, including prescription drug copayments, Annual Deductible and Coinsurance are included in the Out-of-Pocket Maximum.	Annual Deductible and Coinsurance are included in the Out-of-Pocket Maximum.	All Copayments, including prescription drug copayments, Deductibles (Annual Deductible and Prescription Drug Tier 2 and 3 Deductible) and Coinsurance are included in the Out-of-Pocket Annual Maximum.	Annual Deductible and Coinsurance are included in the Out-of-Pocket Maximum.	Annual Deductible and Coinsurance are included in the Out-of-Pocket Maximum.
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 payment of \$15,000 per member for services received from a designated facility (and \$1,500 per member from a facility that is not a designated facility) with a total per occurrence maximum that shall not exceed \$15,000 per member for designated and non-designated facilities combined.				No lifetime maximum for most Covered Services.	No lifetime maximum for most Covered Services.	
COVERED PROVIDERS	HMO Colorado Managed Care Network.	All providers licensed or certified to provide covered benefits.	Anthem Blue Cross and Blue Shield Blue Priority PPO Designated Participating Providers and Participating Provider network. See Provider directory for complete list of current Providers.	All Providers licensed or certified to provide Covered Services.	Blue Priority network, which does not include all Providers in the HMO Colorado managed care network. See Provider directory for complete list of current 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.
WITH RESPECT TO NETWORK PLANS, ARE ALL THE PROVIDERS LISTED ACCESSIBLE TO ME THROUGH MY PRIMARY CARE PHYSICIAN?	Yes	Yes	Yes	Yes	Yes	Yes	

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MEDICAL OFFICE VISITS⁴							
a) Primary Care Providers	\$20 per visit Copayment	Covered person pays 30% after deductible	Designated Participating Providers: \$10 Copayment per office visit. Covered person pays 15% after Deductible for non-laboratory and non-x-ray services. Participating Providers: 15% after Deductible per office visit. Covered person 15% after Deductible for non-laboratory and non-x-ray services.	Covered person pays 35% after deductible	\$20 Copayment per visit.	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible
b) Specialists	\$40 per visit Copayment	Covered person pays 30% after deductible	Designated Participating Providers: \$10 Copayment per office visit. Covered person pays 15% after Deductible for non-laboratory and non-x-ray services. Participating Providers: 15% after Deductible per office visit. Covered person 15% after Deductible for non-laboratory and non-x-ray services.	Covered person pays 35% after deductible	\$60 Copayment per visit.	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible
PREVENTIVE CARE							
a) Children's services	No Copayment (100% covered)	Up to age 13, covered person pays \$30 Copayment per visit. Copayment includes services provided as preventive care.	Designated Participating Providers: No Copayment (100% covered) Participating Providers: No Copayment (100% covered)	Up to age 13, covered person pays no deductible or coinsurance.	Up to age 13, No Copayment (100% covered)	Covered person pays no deductible or coinsurance	\$80 Copayment per office visit
b) Adult's services Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations, contraceptives and office visits; and are not subject to Coinsurance or Deductible.	No Copayment (100% covered)	\$30 Copayment per visit. Copayment includes services provided as preventive care. For covered preventive facility services, covered person pays \$500 Copayment.	Designated Participating Providers: No Copayment (100% covered) Participating Providers: No Copayment (100% covered) For covered preventive facility services, covered person pays no Copayment, however professional services related to the facility visit are subject to the Copayments listed above.	Covered person pays no deductible or coinsurance. For covered preventive facility services, covered person pays \$500 Copayment.	No Copayment (100% covered)	Covered person pays no deductible or coinsurance	\$80 Copayment per office visit. For covered preventive facility services, covered person pays a \$500 Copayment.

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MATERNITY							
a) Prenatal care	One time \$20 Copayment for first prenatal care visit office visit and delivery from the physician.	Covered person pays 30% after deductible	Designated Participating Providers: \$150 Copayment for prenatal care office visit/delivery from the Doctor. Covered person pays 15% after Deductible for non-laboratory and non-x-ray services. Participating Providers: 15% after Deductible for prenatal care office visit/delivery from the Doctor. Covered person pays 15% after Deductible for non-laboratory and non-x-ray services.	Covered person pays 35% after deductible	\$200 global Copayment for prenatal care office visit/delivery from the Doctor.	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible
b) Delivery & inpatient well baby care⁵	\$600 per admission Copayment for facility services.	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	\$250 Copayment per admission then covered person pays 20% after Deductible	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible
INPATIENT HOSPITAL	\$600 per admission Copayment	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	\$250 Copayment per admission then covered person pays 20% after Deductible	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible
OUTPATIENT AMBULATORY SURGERY	\$60 Copayment per date of service at an ambulatory surgery center. \$125 Copayment per date of service at a Hospital or Hospital based facility.	Covered person pays 30% after deductible	Covered person pays 10% after deductible per date of service at an ambulatory surgery center. Covered person pays 15% after deductible at a Hospital or Hospital based facility.	Covered person pays 35% after deductible	\$250 Copayment per admission at an ambulatory surgery center. \$250 Copayment per admission then covered person pays 20% after Deductible at a Hospital.	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible
DIAGNOSTICS							
a) Laboratory & x-ray	Covered person pays no Copayment (100% covered)	Covered person pays 30% after deductible	Covered person pays 10% after deductible per procedure except those services received from either a Hospital or Hospital-based Provider. Covered person pays 15% after deductible for services received from either a Hospital or Hospital-based Provider.	Covered person pays 35% after deductible	No Copayment (100% covered) for laboratory services except those services received from either a Hospital or Hospital-based Provider. Covered member pays a \$60 Copayment per visit for x ray services except those services received from either a Hospital or Hospital-based Provider. \$250 Copayment per visit then covered person pays 20% after Deductible for laboratory and x-ray services received from either a Hospital or Hospital-based Provider.	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible
b) MRI, nuclear medicine, and other high- tech services	\$60 Copayment per procedure except those services received from either a Hospital or Hospital-based Provider. \$120 Copayment per procedure for services received from either a Hospital or Hospital-based Provider.	Covered person pays 30% after deductible	Covered person pays 10% after deductible per procedure except those services received from either a Hospital or Hospital-based Provider. Covered person pays 15% after deductible for services received from either a Hospital or Hospital-based Provider.	Covered person pays 35% after deductible	\$250 Copayment per procedure for MRI/MRA/CT/PET scans except those services received from either a Hospital or Hospital-based Provider. \$250 Copayment per procedure then covered person pays 20% after Deductible for MRI/MRA/CT/PET scans received from either a Hospital or Hospital-based Provider.	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible

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EMERGENCY CARE ⁷	\$150 Copayment per emergency room visit. Copayment waived if admitted to hospital.	Out-of-network care is paid as in network	Covered person pays 15% after deductible. Copayment is waived if admitted.	Out-of-network care is paid as in-network	\$250 Copayment per Emergency room visit. Copayment is waived if admitted. Care is covered In or Out-of-Network.	Covered person pays no coinsurance after deductible	Covered person pays no coinsurance after deductible
AMBULANCE	\$100 per trip Copayment (waived if admitted)	Out-of-network care is paid as in network	Covered person pays 15% after deductible	Out-of-network care is paid as in-network	Covered person pays 20% after Deductible. Care is covered In or Out-of-Network.	Covered person pays no coinsurance after deductible	Covered person pays no coinsurance after deductible. Non-emergency ambulance services are limited to a maximum benefit of \$50,000 per trip.
URGENT, NON-ROUTINE, AFTER HOURS CARE	\$50 per urgent care visit Copayment. Urgent care may be received from your PCP or from an urgent care center.	\$50 per urgent care visit Copayment. Urgent care may be received from your PCP or from an urgent care center.	Covered person pays 15% after deductible	Covered person pays 35% after deductible	\$60 Copayment per visit. Urgent care may be received from your PCP or from an Urgent Care center. Care is covered In or Out-of-Network.	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible
MENTAL HEALTH CARE, ALCOHOL & SUBSTANCE ABUSE CARE							
a) Inpatient care	\$600 per admission Copayment	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	\$250 Copayment per admission then covered person pays 20% after deductible	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible
b) Outpatient care	For outpatient facility services covered person pays no Copayment (100% covered); for outpatient office visits and professional services \$40 Copayment per visit.	Covered person pays 30% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible	For outpatient facility services, covered person pays 20% after Deductible. For outpatient office visits and professional services, covered person pays \$20 Copayment per visit.	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible
PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY From birth until the sixth birthday benefits are provided as required by applicable law.							
a) Inpatient	\$600 Copayment per admission. Limited to 30 non-acute inpatient days per calendar year in and out of network combined.	Covered person pays 30% after deductible.	Included with the Inpatient Hospital benefit. Limited to 30 non-acute inpatient days per calendar year in and out of network combined.	Included with the Inpatient Hospital benefit. Limited to 30 non-acute inpatient days per calendar year in and out of network combined.	\$250 Copayment per admission then covered person pays 20% after Deductible. Limited to 30 inpatient rehab days per calendar year.	Included with Inpatient Hospital benefit (Covered person pays no coinsurance after deductible)	Limited to 30 non-acute inpatient days per calendar year in and out of network combined.
b) Outpatient	\$40 Copayment per visit. Limited to 30 visits per calendar year each for physical, occupational and speech therapy in and out-of-network combined.	Covered person pays 30% after deductible.	Covered person pays 15% after deductible Limited to 60 visits per calendar year combined for physical, speech and occupational therapies in and out-of-network combined.	Covered person pays 35% after deductible Limited to 60 visits per calendar year combined for physical, speech and occupational therapies in and out-of-network combined.	\$20 Copayment per visit. Up to 20 visits each for physical, occupational or speech therapy per calendar year.	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible Up to 20 visits each for physical, occupational or speech therapy per calendar year in and out-of-network combined.
DURABLE MEDICAL EQUIPMENT & OXYGEN	No Copayment (100% covered)	Covered person pays 30% after deductible.	Covered person pays 15% after deductible	Covered person pays 35% after deductible	Covered person pays 50% after Deductible	Covered person pays no 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

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ORGAN TRANSPLANT 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.	\$600 per admission Copayment for inpatient services. \$40 per office visit Copayment See Policy for details.	Covered by HMO Colorado when preauthorized and delivered at a Center of Excellence. Covered person pays 30% after deductible. See Policy for details.	Inpatient Care - Covered person 15% after Deductible. Outpatient Care – Designated Participating Providers: \$10 Copayment for Primary Care Provider or \$20 Copayment for Specialist per office per visit. Covered person pays 15% after Deductible for non-laboratory and non-x-ray services. Participating Providers: Covered person pays 15% after Deductible for Primary Care Provider or for Specialist per office visit. Covered person pays 15% after Deductible for non-laboratory and non-x-ray services. See Policy for details.	Inpatient Care or Outpatient Care Covered person 35% after Deductible. See Policy for details.	Inpatient care - \$250 Copayment per admission then covered person pays 20% after Deductible. Outpatient care - \$20 Copayment per visit for PCP, \$60 Copayment per visit for Specialist.	Covered person pays no coinsurance after deductible.	Not covered
HOME HEALTH CARE	No Copayment (100% covered)	Covered person pays 30% after deductible	No coinsurance (100% covered). Up to 60 visits per calendar year in and out of network combined.	Covered person pays 35% after deductible.	Covered person pays 20% after Deductible. Up to 100 visits per calendar year.	Covered person pays no coinsurance after deductible. Up to 100 visits per calendar year.	Not covered
HOSPICE CARE	No Copayment (100% covered)	Covered person pays 30% after deductible	No coinsurance (100% covered).	Covered person pays 35% after deductible	No Copayment (100% covered)	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible
SKILLED NURSING FACILITY CARE	No Copayment (100% covered). Limited to 60 days per calendar year combined in and out of network.	Covered person pays 30% after deductible.	Covered person pays 15% after deductible Limited to 60 days per calendar year combined in and out of network.	Covered person pays 35% after deductible	Covered person pays 20% after Deductible. Up to 100 days per calendar year.	Covered person pays no coinsurance after deductible	Covered person pays 30% after deductible Up to 100 days per calendar year In and Out-of-Network combined.
DENTAL CARE	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
VISION CARE	Vision benefits can be found on the separate Anthem Vision summary and Benefit Booklet.	Vision benefits can be found on the separate Anthem Vision summary and Benefit Booklet	Vision benefits can be found on the separate Anthem Vision summary and Benefit Booklet	Vision benefits can be found on the separate Anthem Vision summary and Benefit Booklet	Vision benefits can be found on the separate Anthem Vision summary and Benefit Booklet.	Vision benefits can be found on the separate Anthem Vision summary and Benefit Booklet	Vision benefits can be found on the separate Anthem Vision summary and Benefit Booklet
CHIROPRACTIC THERAPY	\$20 per visit Copayment. Limited to 20 visits per calendar year combined with out-of-network	Covered person pays 30% after deductible.	Covered person pays 15% after deductible Limited to 20 visits per calendar year combined with out-of-network	Covered person pays 35% after deductible	\$25 Copayment per visit. 20 visits per calendar year	Covered person pays no coinsurance after deductible 20 visits per calendar year	Not covered

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Massage Therapy/ Acupuncture Care	\$20 Copayment per visit. Limited to 20 visits per calendar year combined	Not covered	Covered person pays 15% after deductible Limited to 20 visits per calendar year combined.	Not covered	\$25 Copayment per visit Limited to 20 visits per calendar year	Covered person pays no coinsurance after deductible Limited to 20 visits per calendar year	Not covered
HEARING AIDS Benefits are covered up to age 18 and are supplied every 5 years, except as required by law.	No Copayment (100% covered).	No Copayment (100% covered).	Benefit level determined by place of service.		Benefit level determined by place of service.		Benefit level determined by place of service.
SECOND OPINIONS	When a member desires another professional opinion, they may obtain a second opinion.						
TREATMENT OF AUTISM SPECTRUM DISORDERS	Benefit level determined by type of service provided.						
SIGNIFICANT ADDITIONAL COVERED SERVICES	BlueCares for You Program	<u>Point of Service Rider</u> For services covered under this rider, a member is not required to get a PCP referral. A member may also choose to receive covered services from a provider who is not in the HMO Colorado network.	<u>Retail Health Clinic</u> -Covered person pays 15% after deductible <u>Nutritional Counseling (other than for eating disorders and Diabetes Management)</u> - Covered person pays 15% after deductible per visit for Specialist. Up to 4 visits per calendar year. <u>Nutritional Counseling for eating disorders</u> - Covered under Mental Health Care. <u>Nutritional Counseling for Diabetes Management</u> - Benefit level determined by place of service. General Information - For outpatient Covered Service not elsewhere listed, Covered person pays Coinsurance after Deductible. For example, this includes chemotherapy and outpatient non-surgical facility services. However, some covered services may require a Copayment prior to and in addition to the Coinsurance.	<u>Retail Health Clinic</u> : \$40 Copayment per visit. <u>Nutritional (other than for eating disorders and Diabetes Management)</u> - \$25 Copayment per visit for Specialist. Up to 4 visits per calendar year. <u>Osteopathic manipulative therapy (OMT)</u> – subject to office visit Copayment, up to a maximum of 6 outpatient visits per calendar year. <u>Nutritional Counseling for eating disorder</u> – covered under Mental Health Care. <u>Nutritional Counseling for Diabetes Management</u> – Benefit level determined by place of service. General Information - For any outpatient Covered Service not elsewhere listed, covered person pays Coinsurance after Deductible. For example this includes chemotherapy and outpatient non-surgical facility services. However, some outpatient Covered Services received from a Hospital may require a \$250 Copayment prior to and in addition to the Deductible and Coinsurance.	<u>Retail Health Clinic</u> : Covered person pays no Coinsurance (100% covered) after Deductible. <u>Nutritional Counseling (other than for eating disorders and Diabetes Management)</u> - Covered person pays no Coinsurance (100% covered) after Deductible. Up to 4 visits per calendar year. <u>Nutritional Counseling for eating disorders</u> – Covered under Mental Health care. <u>Nutritional Counseling for Diabetes Management</u> – Benefit level determined by place of service.	<u>Retail Health Clinic</u> : Not covered <u>Nutritional Counseling (other than for eating disorders and Diabetes Management)</u> - Not covered <u>Nutritional Counseling for eating disorders</u> – Covered under Mental Health care. <u>Nutritional Counseling for Diabetes Management</u> – Benefit level determined by place of service.	

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PRESCRIPTION DRUGS							
Level of coverage and restrictions on prescriptions⁶							
a) Inpatient care	Included with the inpatient hospital benefit	Included with the inpatient hospital benefit	Included with the inpatient Hospital benefit		Included with the inpatient Hospital benefit	Included with the inpatient Hospital benefit	
b) Outpatient care	Retail Pharmacy Drugs - Tier 1 \$10 Copayment, tier 2 \$40 Copayment, tier 3 \$60 Copayment, tier 4 30% Copayment, per prescription at a participating pharmacy up to a 30-day supply. For tier 4 retail pharmacy drugs, the maximum Copayment per prescription is \$125 per 30-day supply.	Not covered	Retail Pharmacy Drugs - Tier 1 \$10 Copayment, tier 2 \$40 Copayment, tier 3 \$60 Copayment, tier 4 30% Copayment, per prescription at a participating pharmacy up to a 30-day supply. For tier 4 retail pharmacy drugs, the maximum Copayment per prescription is \$125 per 30-day supply.	Not covered	Tier 2 and tier 3 outpatient Retail Pharmacy, Specialty Pharmacy and/or Home Delivery Prescription Drugs are first subject to a \$200 Individual / \$400 Family Deductible, once satisfied then services are subject to the Copayment per prescription. Retail Pharmacy Drugs - Tier 1 \$15 Copayment, tier 2 \$40 Copayment, tier 3 \$60 Copayment, tier 4 30% Copayment, per prescription at a participating pharmacy up to a 30-day supply. For tier 4 Retail Pharmacy drugs, the maximum Copayment per prescription is \$250 per 30-day supply.	Retail Pharmacy Drugs - Covered person pays no coinsurance after deductible for up to a 30-day supply.	Retail Pharmacy Drugs - Covered person pays 30% after deductible for up to a 30-day supply.
	Specialty Pharmacy Drugs - Tier 1 \$10 Copayment, tier 2 \$40 Copayment, tier 3 \$60 Copayment, tier 4 30% Copayment, per prescription from our Specialty Pharmacy up to a 30-day supply. For tier 4 Specialty Pharmacy Drugs the maximum Copayment per prescription is \$125 per 30-day supply from our Specialty Pharmacy. Specialty Pharmacy Drugs are not available at a retail pharmacy or from a mail-order pharmacy. Specialty pharmacy drugs are only available through The Pharmacy Benefit Manager (PBM).	Not covered	Specialty Pharmacy Drugs - Tier 1 \$10 Copayment, tier 2 \$40 Copayment, tier 3 \$60 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 \$125 per 30-day supply. Specialty Pharmacy Drugs are not available at a retail pharmacy or from a home delivery pharmacy. Specialty pharmacy drugs are only available through The Pharmacy Benefit Manager (PBM).	Not covered	Specialty Pharmacy Drugs - Tier 1 \$15 Copayment, tier 2 \$40 Copayment, tier 3 \$60 Copayment, tier 4 30% Copayment, per prescription from Our Specialty Pharmacy up to a 30-day supply. For tier 4 Specialty Pharmacy Drugs the maximum Copayment per prescription is \$250 per 30-day supply from Our Specialty Pharmacy. Specialty Pharmacy Drugs are not available at a Retail Pharmacy or from a Home Delivery Pharmacy.	Specialty Pharmacy Drugs - Covered person pays no coinsurance after Deductible per 30-day supply from Anthem Specialty Pharmacy. Specialty Pharmacy Drugs are not available at a Retail Pharmacy or from a Home Delivery Pharmacy.	Specialty Pharmacy Drugs - Not covered
c) Prescription Mail Service	Home Delivery Pharmacy Drugs - Tier 1 \$10 Copayment, tier 2 \$80 Copayment, tier 3 \$120 Copayment, tier 4 30% Copayment, per prescription through the mail-order service up to a 90-day supply. For the tier 4 mail-order drugs, the maximum Copayment per prescription is \$125 per 30-day supply or \$250 per 90-day supply. Specialty pharmacy drugs are only available through the Pharmacy Benefit Manager (PBM).	Not covered	Home Delivery Pharmacy Drugs - Tier 1 \$10 Copayment, tier 2 \$80 Copayment, tier 3 \$120 Copayment, tier 4 30% Copayment, per prescription through the mail-order service up to a 90-day supply. For tier 4 mail-order drugs, the maximum Copayment per prescription is \$125 per 30-day supply or \$250 per 90-day supply. Specialty pharmacy drugs are only available through the Pharmacy Benefit Manager (PBM).	Not covered	Home Delivery Pharmacy Drugs - Tier 1 \$15 Copayment, tier 2 \$80 Copayment, tier 3 \$120 Copayment, tier 4 30% Copayment, per prescription through the Home Delivery Pharmacy up to a 90-day supply. For the tier 4 Home Delivery Pharmacy drugs, the maximum Copayment per prescription is \$250 per 30-day supply or \$500 per 90-day supply. Specialty Pharmacy Drugs are not available through the Home Delivery Pharmacy.	Home Delivery Pharmacy Drugs - Covered person pays no coinsurance after Deductible for up to a 90 day supply. Specialty Pharmacy Drugs are not available through the Home Delivery Pharmacy.	Not covered
	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 tier 1 generic Copayment. The cost difference between the generic and brand-name drug does not contribute to the out-of-pocket annual maximum.						
Asthma & Diabetic Prescription Drugs & Supplies	100% covered from a retail pharmacy or mail-order pharmacy						
	By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness. HMO Colorado reserves the right, at our discretion, to remove certain higher cost generic drugs from this policy. For drugs on our approved list, call customer service at 800-542-9402 .				We reserve the right, at Our discretion, to remove certain higher cost Generic Drugs from this coverage. For drugs on Our approved list, call member services at 877-811-3106 .	We reserve the right, at Our discretion, to remove certain higher cost Generic Drugs from this policy. For drugs on Our approved list, call member services at 866-837-4596 .	

PART C: LIMITATIONS AND EXCLUSIONS

	BlueAdvantage HMO/Point-of-Service (POS)	PRIME Blue Priority PPO Plan	Blue Priority HMO Plan	Lumenos HDHP-PPO Plan
Period during which pre-existing conditions are not covered	Not applicable. Plan does not impose limitation periods for pre-existing conditions. For late enrollees, individual must wait until next open enrollment.			
EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No			
How does the policy define a "pre-existing condition?"	Not applicable. Plan does not exclude coverage for pre-existing conditions.			
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

	BlueAdvantage HMO/Point-of-Service (POS)	PRIME Blue Priority PPO Plan	Blue Priority HMO Plan	Lumenos HDHP-PPO Plan	
Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No	Yes except for care from an OB/GYN, certified nurse midwife, optometrist or ophthalmologist, Autism Services Provider, perinatologists, retail health clinics or Professional Providers for the treatment of Alcohol Dependency, Mental Health Conditions or Substance Dependency. Care from these Providers, if they are participating Providers within the Blue Priority network, may be obtained without a referral.	No	
Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the member is responsible for obtaining pre-certification unless the provider participates with Anthem Blue Cross and Blue Shield. If the provider is in-network , the physician who schedules the procedure or hospital care is responsible for obtaining the pre-certification.	Yes, the member is responsible for obtaining pre-certification unless the provider participates with Anthem Blue Cross and Blue Shield. If the provider is in-network, the physician who schedules the procedure or hospital care is responsible for obtaining the pre-certification.	Yes, the Doctor who schedules the procedure or Hospital care is responsible for obtaining the Preauthorization.	Yes, the Doctor who schedules the procedure or hospital care is responsible for obtaining the Preauthorization.	Yes, you are responsible for obtaining Preauthorization unless the Provider participates with Anthem Blue Cross and Blue Shield.
If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	Yes, unless the provider participates with HMO Colorado or Anthem Blue Cross and Blue Shield or is a PPO Provider	In Network-No Out of Network-Yes, you will be responsible for paying the difference between the Maximum Allowed Amount and the nonparticipating 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.	No	No	Yes, you will be responsible for paying the difference between the Maximum Allowed Amount and the nonparticipating Provider's Billed Charges (sometimes called "balance billing").
What is the main customer service number?	800-542-9402	800-542-9402	800-542-9402	800-542-9402	
Whom do I write/call if I have a complaint or want to file a grievance? ⁸	HMO Colorado Complaints and Appeals 700 Broadway CAT0430 Denver, CO 80273 800-542-9402	Anthem BCBS Complaints and Appeals 700 Broadway Denver, CO 80273 800-542-9402	HMO Colorado, Complaints and Appeals 700 Broadway Denver, CO 80273 877-811-3106	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273 866-837-4596	
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	Write to: Colorado Division of Insurance, ICARE Section, 1560 Broadway, Suite 850 Denver, CO 80202	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202	
Does the plan have a binding arbitration clause?	Yes	Yes	Yes	Yes	
To assist in filing a grievance, indicate the form number of this Large Group policy.	Policy form #'s 98898_GF	Policy form #'s COLGPPONGF Large Group	Policy form #'s COLGHMONGF Large Group	Policy form # COLGCDHPNGF Large Group	

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 **“Annual 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 should vary by policy. Expenses that are subject to deductible may be noted.

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, 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.

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 is 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 **Grievances.** Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

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 and is normally not subject to the deductible or coinsurance.

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 and is normally not subject to the deductible or coinsurance.

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 and is not subject to deductible or coinsurance.

The information above is only a summary of the benefits described. The Booklet includes important additional information about limitations, exclusions and covered benefits. The Schedule of Benefits (Who Pays What) includes additional information about Copayments, Deductibles and Coinsurance. If you have any questions, please call Our member services department at the phone number on the Schedule of Benefits (Who Pays What) form.

**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 <http://colorado.lhiga.com>, email jkelldorf.com or contact:

Colorado Life and Health Insurance Protection Association P.O. Box 36009 Denver, CO 80236 (303) 292-5022	Colorado Division of Insurance 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.