Anthem. Health. Join In.

Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
RightPlan PPO 40
With Comprehensive Prescription Drug Coverage

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but the patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. Deductible Type[2]	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE[2a] a) Individual[2b] b) Family[2c]	 $0 Family coverage not provided	 $0 Family coverage not provided
5. OUT-OF-POCKET ANNUAL MAXIMUM[3] a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	 $3,500 Family coverage not provided No The out-of-pocket annual maximum does not include coinsurance for Other Mental Health Care. Copayment amounts do not apply to out-of-pocket cost sharing requirements, except for inpatient and outpatient hospital copayments (see lines 12 and 13).	 $10,000 Family coverage not provided No The out-of-pocket annual maximum does not include coinsurance for Other Mental Health Care or member costs for not obtaining required preauthorizations. Member cost sharing for visiting a non-participating provider for physical, occupational or speech therapies does not apply to the out-of-pocket cost sharing requirements. Copayment amounts do not apply to out-of-pocket cost sharing requirements, except for inpatient and outpatient hospital copayments (see lines 12 and 13).

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

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

	IN-NETWORK	OUT-OF-NETWORK
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$5,000,000 per member in- and out-of-network combined for all covered services. Morbid obesity surgery has a lifetime maximum Anthem benefit of $7,500 for services received from a Center of Excellence facility or a lifetime Anthem maximum benefit of $1,500 for services received from a facility that has not been designated as a Center of Excellence; total lifetime maximum benefit by the carrier shall not exceed $7,500 per member in- and out-of-network combined. Major organ transplants have a lifetime maximum Anthem benefit of $1,000,000 per transplant in- and out-of-network combined.	$5,000,000 per member in- and out-of-network combined for all covered services. Morbid obesity surgery has a lifetime maximum Anthem benefit of $1,500 for services received from a facility that has not been designated as a Center of Excellence; total lifetime Anthem maximum benefit shall not exceed $7,500 in- and out-of-network combined. Major organ transplants have a lifetime maximum Anthem benefit of $1,000,000 per transplant in- and out-of-network 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 benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes
8. MEDICAL OFFICE VISITS[4]		
a) Primary Care Providers	$40 copayment per office visit plus 40% coinsurance for services other than an office visit.	50% coinsurance
b) Specialists	$40 copayment per office visit plus 40% coinsurance for services other than an office visit. Only limited services are covered as part of an office visit; all other covered services are subject to applicable coinsurance or cost sharing. See line 9 for preventive services, which are limited.	50% coinsurance

	IN-NETWORK	OUT-OF-NETWORK
9. PREVENTIVE CARE a) Children's services	Deductible waived. No coinsurance required for: Early intervention services, preventive services and immunizations (including the cervical cancer vaccination) pursuant to the schedule established by the Advisory Committee on Immunization Practices. Child health supervision services shall be provided up to age 13. Child health supervision services shall be exempt from a deductible or dollar limit provision. Copayments and coinsurance may be imposed for child health supervision services, but they shall not exceed the copayment or coinsurance payment, as applicable, to a physician visit. All other preventive services are not covered.	Deductible waived. No coinsurance required for: Early intervention services, preventive services and immunizations (including the cervical cancer vaccination) pursuant to the schedule established by the Advisory Committee on Immunization Practices. Child health supervision services shall be provided up to age 13. Child health supervision services shall be exempt from a deductible or dollar limit provision. Copayments and coinsurance may be imposed for child health supervision services, but they shall not exceed the copayment or coinsurance payment, as applicable, to a physician visit. All other preventive services are not covered
b) Adults' services	Deductible waived. No coinsurance required for: Routine cytological screening (pap test), mammography benefit in accordance with Colorado law, colorectal cancer examination and related laboratory tests, cholesterol screening, immunizations against cervical cancer, influenza and pneumococcal vaccinations, alcohol misuse and tobacco use screening and behavioral counseling or cessation interventions, and prostate cancer screening. All other preventive services are not covered.	Deductible waived. No coinsurance required for: Routine cytological screening (pap test), mammography benefit in accordance with Colorado law, colorectal cancer examination and related laboratory tests, cholesterol screening, immunizations against cervical cancer, influenza and pneumococcal vaccinations, alcohol misuse and tobacco use screening and behavioral counseling or cessation interventions, and prostate cancer screening. All other preventive services are not covered.
10. MATERNITY a) Prenatal care	Not covered	Not covered
b) Delivery & inpatient well baby care	Delivery not covered. 40% coinsurance plus $500 copayment per day up to 4 days for inpatient well baby care for up to 31-days following birth, adoption or placement for adoption.	Delivery not covered. 50% coinsurance plus $500 hospital copayment per day up to 4 days for inpatient well baby care for up to 31-days following birth, adoption or placement for adoption.
	See certificate for complications of pregnancy coverage.	
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions a) Inpatient care	Included with inpatient hospital (see line 12)	Included with inpatient hospital (see line 12)

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS[6] (continued) b) Outpatient care	Tier 1 generic formulary $10 copayment; Tier 2 brand formulary $30 copayment; Tier 3 non-formulary 50% coinsurance; Tier 4 30% coinsurance for self-administered injectables; At a participating pharmacy up to a 34-day supply.	Not covered
c) Prescription Mail Service	Tier 1 generic formulary $20 copayment; Tier 2 brand formulary $60 copayment; Tier 3 non-formulary 50% coinsurance; Tier 4 30% coinsurance for self-administered injectables; Through the mail order service up to a 90-day supply. All brand name prescription drugs are subject to an annual $500 brand deductible. The $500 brand deductible does not apply to the out-of-pocket annual maximum.	
	In addition to the cost sharing described above, if you purchase a brand-name drug when there is a FDA rated equivalent drug available, you are responsible for the Tier-2 or Tier-3 Copayment for brand-name drugs and you will pay the difference between the cost of the brand-name and the cost of the generic. For example: a Tier-3 brand-name prescription costs $100; a generic Tier-1 substitution is available, the generic prescription costs $60, you pay the $40 difference plus the Tier-3 (50% coinsurance) for a total member cost of $90. The $40 difference is not applied toward any other cost-sharing requirement. See certificate for details. For drugs on our approved list, contact Customer Service at 888-231-5046. Covered only when received from a participating pharmacy.	Not covered
12. INPATIENT HOSPITAL	$500 copayment per day up to 4 days, plus 40% coinsurance. Hospital copayment amounts will be applied to out-of-pocket cost sharing requirements.	$500 copayment per day up to 4 days plus 50% coinsurance. Hospital copayment amounts will be applied to out-of-pocket cost sharing requirements.
13. OUTPATIENT/AMBULATORY SURGERY	$500 copayment per surgical admission, plus 40% coinsurance. Hospital copayment amounts will be applied to out-of-pocket cost sharing requirements.	$500 copayment per surgical admission plus 50% coinsurance. Hospital copayment amounts will be applied to out-of-pocket cost sharing requirements.

	IN-NETWORK	OUT-OF-NETWORK
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine and other high-tech services	 40% coinsurance 40% coinsurance	 50% coinsurance 50% coinsurance
15. EMERGENCY CARE[7,8]	$100 emergency room copayment (waived if admitted), plus 40% coinsurance	$100 emergency room copayment (waived if admitted), plus 50% coinsurance
16. AMBULANCE	$100 copayment	$100 copayment
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$40 office visit copayment plus 40% coinsurance for services other than an office visit See line 15 for emergency room care	50% coinsurance See line 15 for emergency room care
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Biologically-Based Mental Illness Care is paid as Other Mental Health Care, see line 19.	Biologically-Based Mental Illness Care is paid as Other Mental Health Care, see line 19.
19. 0THER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	 All charges except $175 per day. Limited to 30 days in each benefit year in- and out-of-network combined. All charges except $25 per visit. Limited to 20 visits in each benefit year, in-and out-of-network combined. Maximum Anthem benefit for inpatient and outpatient care is limited to $10,000 per lifetime, in-and out-of-network combined.	 All charges except $175 per day. Limited to 30 days in each benefit year in- and out-of-network combined. All charges except $25 per visit. Limited to 20 visits in each benefit year, in-and out-of-network combined. Maximum Anthem benefit for inpatient and outpatient care is limited to $10,000 per lifetime, in-and out-of-network combined.
20. ALCOHOL & SUBSTANCE ABUSE a) Inpatient Care b) Outpatient care	 Not covered Not covered	 Not covered Not covered

	IN-NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY a) Inpatient	40% coinsurance. Covered for inpatient rehabilitation therapy for up to 30 days permember in each benefit year, in- and out-of-network combined.	50% coinsurance. Covered for inpatient rehabilitation therapy for up to 30 days per member in each benefit year, in- and out-of-network combined.
b) Outpatient	40% coinsurance Physical and occupational therapy is limited to a combination of 12 visits in each benefit year in- and out-of-network combined, except for children to age 5 (see certificate for details). Speech therapy is limited to 50 visits in each benefit year, in- and out-of-network combined, except for children to age 6 (see certificate for details).	Participating Providers: 50% coinsurance Non-Participating Providers: All charges except $25 per visit Physical and occupational therapy is limited to a combination of 12 visits in each benefit year in- and out-of-network combined, except for children to age 5 (see certificate for details). Speech therapy is limited to 50 visits in each benefit year, in- and out-of-network combined, except for children to age 6 (see certificate for details).
22. DURABLE MEDICAL EQUIPMENT	40% coinsurance. See certificate for types and circumstances of coverage. For prosthetic devices (arms and legs), benefits are at least equal to those benefits provided under federal law for health insurance for the aged and disabled, if applicable. Footwear is limited to a $400 maximum Anthem benefit per member's benefit year, in- and out-of-network combined. Wigs are limited to a $400 maximum Anthem benefit per member's year, in- and out-of-network combined.	50% coinsurance. See certificate for types and circumstances of coverage. Footwear is limited to a $400 maximum Anthem benefit per member's benefit year, in- and out-of-network combined. Wigs are limited to a $400 maximum Anthem benefit per member's benefit year, in- and out-of-network combined.
23. OXYGEN	40% coinsurance	50% coinsurance
24. ORGAN TRANSPLANTS	40% coinsurance. See certificate for details.	50% coinsurance. See certificate for details.
25. HOME HEALTH CARE	40% coinsurance. Limited to 60 visits in each benefit year, in-and out-of-network combined.	50% coinsurance. Limited to 60 visits in each benefit year, in-and out-of-network combined.
26. HOSPICE CARE a) Inpatient Care	40% coinsurance	50% coinsurance
b) Outpatient care	40% coinsurance. Limited to $100 maximum Anthem benefit per day with a maximum benefit of 91 visits in each benefit period, in-and out-of-network combined. See certificate for details.	50% coinsurance. Limited to $100 maximum Anthem benefit per day with a maximum benefit of 91 visits in each benefit period, in-and out-of-network combined. See certificate for details.
27. SKILLED NURSING FACILITY CARE	Not covered	Not covered
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Not covered	Not covered
30. CHIROPRACTIC CARE	Not covered	Not covered

	IN-NETWORK	OUT-OF-NETWORK
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Dental injury – 40% coinsurance Smoking cessation program – All charges except $50 per lifetime, in-and out-of-network combined. Benefits are provided for diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams (40% coinsurance after deductible). Insulin pumps and related supplies are covered subject to meeting Anthem's medical policy criteria. When diabetic supplies are provided by a pharmacy they are covered under the prescription drug benefits and subject to the prescription copayment. When a member desires another professional opinion, they may obtain a second surgical opinion.	Dental injury – 50% coinsurance Smoking cessation program – All charges except $50 per lifetime, in-and out-of-network combined. Benefits are provided for diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams (40% coinsurance after deductible). Insulin pumps and related supplies are covered subject to meeting Anthem's medical policy criteria. When diabetic supplies are provided by a pharmacy they are covered under the prescription drug benefits and subject to the prescription copayment. When a member desires another professional opinion, they may obtain a second surgical opinion.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. [10]	12 months for all pre-existing conditions unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health-care professional, or took prescription drugs within 12 months immediately preceding the effective date of coverage.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan, sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes	Yes, the member is responsible for obtaining pre-certification unless the provider participates with Anthem Blue Cross and Blue Shield.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
39. What is the main customer service number?	888-231-5046	
40. Whom do I write/call if I have a complaint or want to file a grievance?[11]	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273 888-231-5046	
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 05-74, individual	

[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

[2] "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or "Per Confinement."

[2a] "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

[2b] "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

[3] "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum should be noted in boxes 8 through 31.

[4] Medical office visits include physician, mid-level practitioner, and specialist visits, 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 if complication of pregnancy and well-baby together: there are not separate copayments.

[6] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

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

[8] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan or non-emergency after-hours care, then urgent care copayments apply.

[9] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[10] Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

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

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

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

Pursuant to Colorado law (C.R.S. §10-16-107(7)(a), services or supplies for the treatment of Intractable Pain and/or Chronic Pain are not covered.

This coverage is renewable at your option, except for the following reasons:

1. **Non-payment of the required premium;**
2. **Fraud or intentional misrepresentation of material fact on the part of the plan sponsor;**
3. **The commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations;**
4. **The carrier elects to discontinue offering and non-renew all of its individual plans delivered or issued for delivery in Colorado.**

Cancer Screenings

At Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Colorado, Inc., we believe cancer screenings provide important preventive care that supports our mission: to improve the health of the people we serve. We cover cancer screenings as described below.

At Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Colorado, Inc., we believe cancer screenings provide important preventive care that supports our mission: to improve the lives of the people we serve and the health of our communities. We cover cancer screenings as described below.

Pap Tests

All plans provide coverage for an annual Pap test and the related office visit. Payment for the Pap test is based on the plan's laboratory services provisions, and payment for the related office visit is based on the plan's preventive care provisions.

Mammogram Screenings

All plans except our HMO and PPO Basic Health Plans provide mammogram screening coverage for women in accordance with the "A" and "B" recommendations of the U.S. Preventive Services Task Force. Frequency guidelines can be found in your certificate. Payment for the mammogram screening benefit is based on the plan's provisions for X-ray services.

Prostate Cancer Screenings

All plans except our HMO and PPO Basic Health Plans provide prostate cancer screening coverage for men 40 years of age and older. Frequency guidelines can be found in your certificate. Payment for the prostate cancer screening benefit is based on the plan's provisions for X-ray services.

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.

The information above is only a summary of the benefits described. The certificate for each health plan includes important additional information about limitations, exclusions and covered benefits. The Health Benefit Plan Description Form for each health plan includes additional information about copayments, deductibles and coinsurance. If you have any questions, please call our customer service department at the phone number on the Health Benefit Plan Description Form.