Schedule of Benefits (Who Pays What)

HMO Colorado

Name of Carrier

BlueAdvantage HMO Plan $25-$250

Name of Plan

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 Precertification, prior authorization, a referral from your Primary Care Provider, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4. DEDUCTIBLE TYPE[2]	Calendar Year
4a. ANNUAL DEDUCTIBLE[2a]	
a) Individual[2b]	No Deductible
b) Family[2c]	No Deductible

Si usted necesita ayuda en español para entender este documento, puede solicitarla gratis llamando al numero de servicio al cliente que aparece en su tarjeta de identificacion o en su folleto de inscripcion.

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

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
5. OUT-OF-POCKET ANNUAL MAXIMUM[3]	
a) Individual	$1,000 Copayments and Coinsurance are included in the Out-of-Pocket Annual Maximum.
b) Family	$2,000 Copayments and Coinsurance are included in the Out-of-Pocket Annual Maximum. One Member may not contribute any more than the individual Out-of-Pocket Annual Maximum towards the family Out-of-Pocket Annual Maximum.
c) Is deductible included in the out-of-pocket maximum?	Not applicable Some Covered Services have a maximum benefit of days, visits or dollar amounts. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum for most Covered Services.
7A. COVERED PROVIDERS	HMO Colorado managed care network. See Provider directory for complete list of current Providers.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my Primary Care Provider?	Yes
8. MEDICAL OFFICE VISITS[4]	
a) Primary Care Providers	$25 Copayment per visit
b) Specialists	$25 Copayment per visit
9. PREVENTIVE CARE	
a) Children's services	No Copayment (100% covered)
b) Adult's services	No Copayment (100% covered) 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.
10. MATERNITY	
a) Prenatal care	$25 Copayment for the first prenatal care office visit/delivery from the Doctor
b) Delivery & inpatient well baby care[5]	$250 Copayment per admission
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions[6]	**Inpatient care** - Included with the inpatient Hospital benefit (see line 12). **Outpatient care - Retail Pharmacy Drugs** - Tier 1 $8 Copayment, Tier 2 $25 Copayment, Tier 3 $45 Copayment, per prescription at a participating pharmacy up to a 30-day supply.

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
	Tier 1, Tier 2 and Tier 3 non-specialty Maintenance Drugs may be filled up to a 90-day supply at most Retail Pharmacy locations. You are required to pay a Retail Pharmacy Copayment for each 30-day supply. **Outpatient Care - Specialty Pharmacy Drugs** - Tier 1 $8 Copayment, Tier 2 $25 Copayment, Tier 3 $45 Copayment, per prescription up to a 30-day supply. Certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy. When you get Specialty Drugs from the Specialty Pharmacy, you will have to pay the same Copayment you pay for a 30-day supply at a Retail Pharmacy. **Outpatient Care - Home Delivery Pharmacy Drugs** - Tier 1 $16 Copayment, Tier 2 $50 Copayment, Tier 3 $90 Copayment, per prescription through the Home Delivery Pharmacy up to a 90-day supply. Specialty pharmacy drugs are not available through the Home Delivery Pharmacy.
12. INPATIENT HOSPITAL	$250 Copayment per admission
13. OUTPATIENT / AMBULATORY SURGERY AT A FACILITY	No Copayment (100% covered) per date of service
14. DIAGNOSTICS **a) Laboratory & x-ray** **b) MRI, nuclear medicine, and other high-tech services**	 No Copayment (100% covered) for laboratory and x-ray services No Copayment (100% covered) per procedure
15. EMERGENCY CARE[7]	$100 Copayment per Emergency room visit. Copayment is waived if admitted. Care is covered In or Out-of-Network.
16. AMBULANCE	No Copayment (100% covered) per trip. Care is covered In or Out-of-Network.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$50 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.
18. MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	 $250 Copayment per admission For outpatient facility services, you pay no Copayment (100% covered); for outpatient office visits and professional services $25 Copayment per visit. Mental health care includes without limitation, biologically based mental illness, care that has a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition.
19. ALCOHOL & SUBSTANCE ABUSE **a) Inpatient care** **b) Outpatient care**	 $250 Copayment per admission For outpatient facility services, you pay no Copayment (100% covered); for outpatient office visits and professional services $25 Copayment per visit.

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
20. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY **a) Inpatient care**	$250 Copayment per admission. Up to 30 inpatient rehab days per calendar year.
b) Outpatient care	$25 Copayment per visit. Up to 20 visits each for physical, occupational and speech therapy per calendar year. From birth until the Member's sixth birthday, benefits are provided as required by applicable law.
21. DURABLE MEDICAL EQUIPMENT	You pay no Coinsurance (100% covered). One wig after cancer treatment up to a maximum benefit of $500 per Member.
22. OXYGEN	You pay no Coinsurance (100% covered)
23. ORGAN TRANSPLANTS **a) Inpatient care**	$250 Copayment per admission
b) Outpatient care	$25 Copayment per visit for PCP. $25 Copayment per visit for Specialist. 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.
24. HOME HEALTH CARE	No Copayment (100% covered). Up to 100 visits per calendar year.
25. HOSPICE CARE	No Copayment (100% covered)
26. SKILLED NURSING FACILITY CARE	No Copayment (100%) covered. Up to 100 days per calendar year.
27. DENTAL CARE	Not covered
28. VISION CARE	Not covered
29. CHIROPRACTIC THERAPY	$25 Copayment per visit. Up to 20 visits per calendar year, regardless of which type of Provider renders the therapy.
30. SIGNIFICANT ADDITIONAL COVERED SERVICES	**Retail Health Clinic** $25 Copayment per visit **Other Covered Services** **Nutritional Counseling (other than for eating disorders and Diabetes Management) -** $25 Copayment per visit for Specialist. Up to 4 visits per calendar year. **Nutritional Counseling for eating disorders** - Covered under Mental Health Care, please see row 19. **Nutritional Counseling for Diabetes Management** - Benefit level determined by place of service. **Hearing Aids** Child - Benefit level determined by place of service. Hearing aids are covered up to age 18. Initial and replacement hearing aids will be supplied every 5 years. New hearing aid will be a covered service when alterations to your existing hearing aid cannot adequately meet your needs or be repaired. Adult – You pay no Coinsurance (100% covered). Limited to one (1) device per ear every three (3) years.

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
	Applied Behavioral Analysis Services Benefits based on the setting in which Covered Services are received.

PART C: LIMITATIONS AND EXCLUSIONS

31. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.	Not applicable; plan does not impose limitation periods for pre-existing conditions.
32. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
33. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Not applicable; plan does not exclude coverage for pre-existing conditions.
34. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK
35. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No
36. Is Precertification required for surgical procedures and hospital care (except in an emergency)?	Yes, the Doctor who schedules the procedure or Hospital care is responsible for obtaining the Precertification.
37. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
38. What is the main member service number?	877-811-3106
39. Whom do I write/call if I have a complaint or want to file a grievance?	HMO Colorado, Complaints and Appeals 700 Broadway Denver, CO 80273 877-811-3106
40. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202
41. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form #'s COLGHMONGF Large Group
42. Does the plan have a binding arbitration clause?	Yes

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

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

[2a] "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 30.

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

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

[3] "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan.

[4] Medical office visits include physician, mid-level practitioner, and specialist visits.

[5] Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother and well-baby together: there are not separate copayments.

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

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

Cancer Screenings

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

Pap Tests

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

Mammogram Screenings

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

Prostate Cancer Screenings

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

Colorectal Cancer Screenings

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

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) section 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.