Colorado Higher Education Insurance Benefits Alliance Trust
Anthem BCBS BluePriority HMO

Coverage Period: Plan Year 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://eoc.anthem.com/eocdps/fi or by calling 1-800-542-9402.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In-Network: **$2,000** Individual/**$6,000** Family Deductible does not apply to preventive care or copayments.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. There is a separate $200 deductible per individual or $400 deductible per family for outpatient Tier 2 and Tier 3 prescription drugs.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For In-Network: **$4,000** Individual/**$10,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com or call 1-800-542-9402 for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Do I need a referral to see a specialist?	Yes.	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.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit	Not covered	See separate benefit for diagnostic test services.
	Specialist visit	$60/visit	Not covered	See separate benefit for diagnostic test services.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Other practitioner office visit	$25/visit	Not covered	Chiropractic therapy limited to 20 visits per calendar year. Acupuncture and massage therapy limited to a combined maximum of 20 visits per calendar year. Nutritional counseling limited to a maximum of 4 visits per calendar year. See separate benefit for diagnostic test services.
	Preventive care/ screening/immunization	No copayment (100% covered)	Not covered	Covered preventive care services are not subject to deductible.
If you have a test	Diagnostic test (x-ray, blood work)	Office Lab – No copayment (100% covered); Office X-Ray - $60/visit; Hospital Lab/X-Ray – $250/procedure plus 20% coinsurance after deductible	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	Office Imaging – $250/procedure; Hospital Imaging – $250/procedure plus 20% coinsurance after deductible	Not covered	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Tier 1 Generic drugs	$15/prescription (Retail/Mail Order)	Not covered	Retail copay includes a 30-day supply; Mail Order copay includes a 90-day supply. Tier 2 and Tier 3 outpatient drugs are subject to a $200 deductible per individual or a $400 deductible per family, once satisfied then services are subject to the copayment.
	Tier 2 Preferred brand drugs	$40/prescription (Retail); $80/prescription (Mail Order)	Not covered	
	Tier 3 Non-preferred brand drugs	$60/prescription (Retail); $120/prescription (Mail Order)	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
www.anthem.com	Tier 4 drugs	30% copayment with a maximum payment of $250/ prescription (Retail); or $500/prescription (Mail Order)	Not covered	Certain specialty drugs must be ordered through a specialty pharmacy; see the contract plan for details. Specialty drugs are not eligible for the 90 day Mail Order program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgery Center – $250/admission; Hospital – $250/admission then 20% coinsurance after deductible	Not covered	——————none——————
	Physician/ surgeon fees	Ambulatory Surgery Center – No coinsurance or copayment (100% Covered); Hospital – 20% coinsurance after deductible	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$250/visit	Out-of-Network paid as In-Network	Copayment is waived if admitted.
	Emergency medical transportation	20% coinsurance after deductible	Out-of-Network paid as In-Network	——————none——————
	Urgent care	$60/visit	Out-of-Network paid as In-Network	See separate benefit for diagnostic test services.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/admission plus 20% coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
	Physician/surgeon fee	20% coinsurance after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20/office visit, or 20% coinsurance after deductible for outpatient facility services	Not covered	Copayment applies to office visits and professional services; coinsurance after deductible charged for facility services.
	Mental/Behavioral health inpatient services	$250/admission plus 20% coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
	Substance use disorder outpatient services	$20/office visit, or 20% coinsurance after deductible for outpatient facility services	Not covered	Copayment applies to office visits and professional services; coinsurance after deductible charged for facility services.
	Substance use disorder inpatient services	$250/admission plus 20% coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
If you are pregnant	Prenatal and postnatal care	$200/pregnancy for prenatal care office visits and delivery from the doctor	Not covered	See separate benefit for diagnostic test services.
	Delivery and all inpatient services	$250/admission plus 20% coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not covered	Home health care is limited to 100 visits per calendar year.
	Rehabilitation services	Outpatient Care: $20/visit; Inpatient Care: $250/admission plus 20% coinsurance after deductible	Not covered	Outpatient coverage of physical, occupational and speech therapies is limited to 20 visits each per calendar year. Inpatient benefit for therapies is limited to 30 inpatient rehab days per calendar year. Cardiac Rehabilitation is limited to 36 visits per calendar year. See separate benefit for diagnostic test services.
	Habilitation services	Outpatient Care: $20/visit; Inpatient Care: $250/admission plus 20% coinsurance after deductible	Not covered	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	20% coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage. Covers up to 100 days per calendar year.
	Durable medical equipment	50% coinsurance after deductible	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
	Hospice service	No deductible or coinsurance (100% covered)	Not covered	Failure to obtain pre-authorization may result in reduced or no coverage.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	——————none——————
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- Routine foot care unless you have been diagnosed with diabetes.
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (limits apply)
- Chiropractic care (limits apply)
- Emergency care provided outside the United States. See www.BCBS.com/bluecardworldwide
- Hearing aids (limits apply)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at your Human Resources Department. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross and Blue Shield
Appeals Department
700 Broadway, CAT CO0104-0430
Denver, CO 80273

Additionally, a consumer assistance program can help you file your appeal. Contact:

Colorado Division of Insurance
ICARE Section
1560 Broadway, Suite 850
Denver, CO 80202

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíiłkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,810
- **Patient pays** $2,730

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,200
Copays	$530
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,730**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,280
- **Patient pays** $2,120

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$620
Coinsurance	$0
Limits or exclusions	$0
Total	**$2,120**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.