PART A: TYPE OF COVERAGE

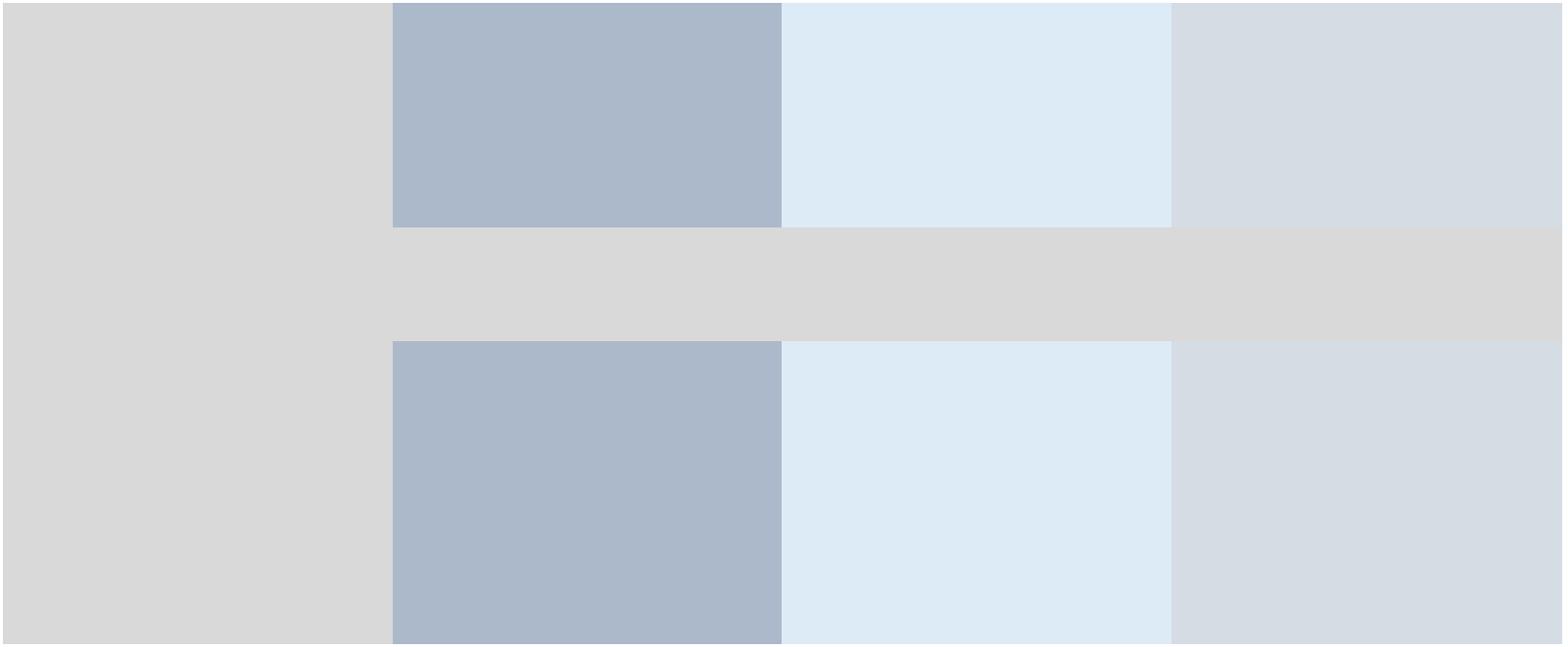
TYPE OF PLAN OUT-OF-NETWORK CARE COVERED?[1]			

	In Network (HMO)	Out of Network (POS)	In Network	Out of Network	In Network	Out of Network
OUT-OF-POCKET ANNUAL MAXIMUM[3]						
a) Individual (Single)	$3,500	$7,000	$3,500	$7,000	$3,500	$7,000
b) Family (Non-Single)	$7,000	$14,000	$7,000	$14,000	$7,000	$14,000
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. Pre-Authorization Penalties do not count toward the out-						

	In Network (HMO)	Out of Network (POS)	In Network	Out of Network	In Network	Out of Network
MATERNITY						
a) Prenatal care	One time $25 Copayment for first prenatal care visit office visit and delivery from the physician.	Covered person pays 40% 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 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible
b) Delivery & inpatient well baby care						

b) MRI, nuclear medicine, and other high- tech services ***Rural - Applies to below entities only:*** *Adams State University* *Western Colorado University* *Ft. Lewis College*	$100 Copayment per procedure plus deductible except those services received from either a Hospital or Hospital-based Provider. $250 Copayment per procedure plus deductible for services received from either a Hospital or Hospital-based Provider. *__Rural__: $150 per procedure plus deductible	Covered person pays 40% 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 40% after deductible	Covered person pays 15% after deductible

EMERGENCY CARE [7]	**In Network (HMO)**	**Out of Network (POS)**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
	$300 Copayment per emergency room vo NY CARE.4 (c)-8.2 (y)]TJETQq0 g/TT1 1 Tf0.008 Tc -0.01RE9Q	q0 g/TT1 1 Tf0.008 Tc -0.01RE9Q	q0 g/TT1 1 Tf0.008 Tc -0.01RE9Q	q0 g/TT1 1 Tf0.008 Tc -4 (c)-8.2 (y)]TJETQq0 g/TT1 1 Tf0.008 Tc -0.01RE9Q	q0 g/TT1 1 Tf0.008 Tc -0.01RE9Q	q0 g/TT1 1 Tf0.008 Tc -0.01RE9Q



	In Network (HMO)	Out of Network (POS)	In Network	Out of Network	In Network	Out of Network
PRESCRIPTION DRUGS						
Level of coverage and restrictions on prescriptions[6]						
a) Inpatient care	Included with the inpatient					

c) Home Delivery Pharmacy Drugs	**Home Delivery Pharmacy Drugs** - Tier 1 $25 Copayment Tier 2 20% coinsuranxce (max $125) Tier 3 30% coinsurance (max $187.50) Tier 4 20% coinsurance up to $150 max (30-day max) Tier 5 30% coinsurance up to $250 max (30-day max) Per prescription through the home delivery service up to a 90-day supply. Specialty pharmacy drugs are not available through the Home Delivery Pharmacy.	Not covered	**Home Delivery Pharmacy Drugs -** Tier 1 $25 Copayment Tier 2 20% coinsuranxce (max $125) Tier 3 30% coinsurance (max $187.50) Tier 4 20% coinsurance up to $150 max (30-day max) Tier 5 30% coinsurance up to $250 max (30-day max) Per prescription through the home delivery service up to a 90-day supply. Specialty pharmacy drugs are not available through the Home Delivery Pharmacy.	Not covered	Home Delivery Pharmacy Drugs - Covered person pays 15% after deductible for up to a 90 day supply. Specialty Pharmacy Drugs are not available through the Home Delivery Pharmacy.	Not covered

Asthma & Diabetic Prescription Drugs & Supplies	Prov ofidh545.88 Tm2(s)-4 (e DD 91.44 Tm 1.ug)/P Acc5K1 (v)3ui s545.88 Tm2d 5 (e)-9iœeh.007 Tc ic5KR5 (e6.4 5 (e21.6 /P Aul (8 Tm2.007 Tc 0.7 7.45.88 Tm2(s)-6-9n)]J-,t)0.5Kh(s)-6-9w)11te54 5 (e)-9icsc5Kh.0			
	Everside Health is a provider of primary care services that has recently become available to CHEIBA members who reside in the areas where Everside clinics are established. Members in these locations may select a Everside physician as their Primary Care Provider (PCP). Please contact your Employer or Customer Service for additional details.			
Period during which pre-existing conditions are not covered **EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?** **How does the policy define a "pre-existing condition?"** **What treatments and conditions are excluded under this policy?**				
PART D: USING THE PLAN				
Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases? **Is prior authorization 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 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?				
What is the main customer service number? **Whom do I write/call if I have a complaint?** **Whom do I write/call if I want to file an Appeal or grievance?[8]** **Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?** **Does the plan have a binding arbitration clause?**				

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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.