HMO Colorado/Anthem Blue Cross and Blue Shield
Colorado Higher Education Insurance Benefits Alliance Trust
Effective January 1, 2026

PART A: TYPE OF COVERAGE

	Blue Advantage HMO/Point-of-Service (POS) Plan	PRIME Blue Priority PPO Plan	2500 HDHP-PPO Plan
TYPE OF PLAN	HMO with PPO Rider (Tiered Plan)	Preferred Provider Plan (Tiered Plan)	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	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 (including Longmont), Broomfield, Denver, Douglas, Elbert, El Paso, Fremont, Jefferson, La Plata, Larimer, Mesa, Montrose, Montezuma, Pueblo, Summit, Teller & Weld counties. Participating Providers are available throughout Colorado	Plan is available throughout Colorado
Grandfathered Health Plan	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.

	BlueAdvantage HMO/Point-of-Service (POS)		PRIME Blue Priority PPO Plan		2500 HDHP-PPO Plan	
	In Network (HMO) Tier 1	**Out of Network - Tier 2 (PPO)/Tier 3 (OON)**	**In Network - Tier 1/Tier 2**	**Out of Network - Tier 3**	**In Network**	**Out of Network**
Deductible Type [2]	Calendar Year		Calendar Year		Calendar Year	
ANNUAL DEDUCTIBLE[2a]						
a) Individual (Single)[2b]	$500	$3,000	$600, excludes Copayments	$3,000	$2,500	$2,500
b) Family[2c] (Non-Single)	$1,000	$6,000	$1,200, excludes Copayments	$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.		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.

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.

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OUT-OF-POCKET ANNUAL MAXIMUM[3]						
a) Individual (Single)	$3,750	$7,500	$3,750	$7,500	$3,750	$7,500
b) Family (Non-Single)	$7,500	$15,000	$7,500	$15,000	$7,500	$15,000
	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. Pre-Authorization Penalties do not count toward the out-of-pocket annual maximum. 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.	Annual Deductible, Coinsurance and any 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.	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.	
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.	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	

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	In Network (HMO) Tier 1	**Out of Network Tier 2 (PPO)/Tier 3 (OON)**	**In Network - Tier 1/Tier 2**	**Out of Network - Tier 3**	**In Network**	**Out of Network**
MEDICAL OFFICE VISITS[4]						
a) Primary Care Providers	$25 per visit Copayment	Covered person pays 40% after deductible	**Designated Participating Providers:** $10 Copayment per office visit. Covered person pays 20% after Deductible for non-laboratory and non-x-ray services. **Participating Providers**: 20% after Deductible per office visit. Covered person 20% 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) Specialists	$50 per visit Copayment	Covered person pays 40% after deductible	**Designated Participating Providers**: $10 Copayment per office visit. Covered person pays 20% after Deductible for non-laboratory and non-x-ray services. **Participating Providers:** 20% after Deductible per office visit. Covered person 20% 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
PREVENTIVE CARE						
a) Children's services	No Copayment (100% covered)	$30 Copayment per visit. Copayment includes services provided as preventive care.	**Designated Participating Providers:** No Copayment (100% covered) **Participating Providers:** No Copayment (100% covered)	Covered person pays no deductible or coinsurance (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.	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 $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 20% after Deductible for non-laboratory and non-x-ray services. **Participating Providers:** 20% after Deductible for prenatal care office visit/delivery from the Doctor. Covered person pays 20% 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) Childbirth/delivery facility services	Covered person pays 10% after deductible	Covered person pays 40% after deductible	Covered person pays 20% after deductible	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible
c) Childbirth/delivery professional services[5]	No charge	Covered person pays 40% after deductible	Covered person pays 20% after deductible	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible
INPATIENT HOSPITAL (Facility Services)	Covered person pays 10% after deductible	Covered person pays 40% after deductible	Covered person pays 20% after deductible	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible
Inpatient professional services	No charge	Covered person pays 40% after deductible	Covered person pays 20% after deductible	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible
OUTPATIENT AMBULATORY SURGERY ***Rural - Applies to below entities only:*** *Adams State University* *Western Colorado University* *Ft. Lewis College*	$125 Copayment per date of service plus deductible at an ambulatory surgery center. $250 Copayment per date of service plus deductible at a Hospital or Hospital based facility. ***Rural**: $175 Copayment per date of service plus deductible	Covered person pays 40% after deductible	Covered person pays 10% after deductible per date of service at an Ambulatory Surgery Center. Covered person pays 20% after deductible at a Hospital or Hospital based facility.	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible

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DIAGNOSTICS						
a) Laboratory & x-ray	Covered person pays no Copayment (100% covered)	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 20% 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	Covered person pays 35% after deductible
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 20% 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	Covered person pays 35% after deductible

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EMERGENCY CARE [7]	$300 Copayment per emergency room visit (Deductible does not apply). Waived if admitted	Out-of-network care is paid as in network	$300 Copayment per emergency room visit (Deductible does not apply). Waived if admitted	Out-of-network care is paid as in-network	Covered person pays 15% after deductible	Covered person pays 15% after deductible
EMERGENCY MEDICAL TRANSPORTATION	$100 per trip Copayment (waived if admitted)	Out-of-network care is paid as in network	Covered person pays 20% after deductible	Out-of-network care is paid as in-network	Covered person pays 15% after deductible	Out-of-network care is paid as in-network. Non-emergency ambulance services are limited to a maximum benefit of $50,000 per trip.
URGENT, NON-ROUTINE, AFTER HOURS CARE	$75 per urgent care visit Copayment (Deductible does not apply). Urgent care may be received from your PCP or from an urgent care center.	$75 per urgent care visit Copayment (Deductible does not apply). Urgent care may be received from your PCP or from an urgent care center.	$75 per urgent care visit Copayment (Deductible does not apply). Urgent care may be received from your PCP or from an urgent care center.	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible
MENTAL HEALTH CARE, ALCOHOL & SUBSTANCE ABUSE CARE 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.						
INPATIENT HOSPITAL (Facility Services)	Covered person pays 10% after deductible	Covered person pays 40% after deductible	Covered person pays 20% after deductible	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible
Inpatient professional services	No charge	Covered person pays 40% after deductible	Covered person pays 20% after deductible	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible
b) Outpatient care	For outpatient facility services covered person pays no Copayment (100% covered); for outpatient office visits and professional services $25 Copayment per visit.	Covered person pays 40% after deductible	Covered person pays 20% after deductible	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible

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PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY **From birth until the sixth birthday benefits are provided as required by applicable law.**						
INPATIENT HOSPITAL	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 Inpatient Hospital benefit	
	Limited to 30 non-acute inpatient days per calendar year in and out of network combined.		Limited to 30 non-acute inpatient days per calendar year in and out of network combined.		Limited to 30 non-acute inpatient days per calendar year in and out of network combined.	
b) Outpatient (Clinic setting)	$25 Copayment per visit.	Covered person pays 40% after deductible.	$10 Copayment per office visit.	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible
	Limited to 30 visits per calendar year each for physical, occupational and speech therapy in and out-of-network combined.		Limited to 60 visits per calendar year combined for physical, speech and occupational therapies in and out-of-network combined.		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 40% after deductible.	Covered person pays 20% after deductible	Covered person pays 40% after deductible	Covered person pays 15% after deductible.	Not covered
WIGS (FOR ALOPECIA RESULTING FROM CHEMOTHERAPY AND RADIATION)	1 Per Calendar Year		1 Per Calendar Year		1 Per Calendar Year with a Maximum of $500	

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ORGAN TRANSPLANT Transportation and lodging services are limited to a maximum benefit of $10,000 per Transplant procedure per Benefit Period; Bone marrow donor searches are limited to a maximum benefit of $30,000 per Transplant. **Covered when preauthorized.**	**Inpatient (Facility services):** Covered person pays 10% after deductible **PCP** $25 per office visit Copayment **Specialist** $50 per office visit Copayment See Policy for details.	Covered person pays 40% after deductible. See Policy for details.	**Inpatient Care** - Covered person 20% after Deductible. **Outpatient Care – Designated Participating Providers:** $10 Copayment for Primary Care Provider or $10 Copayment for Specialist per office per visit. Covered person pays 20% after Deductible for non-laboratory and non-x-ray services. **Participating Providers:** Covered person pays 20% after Deductible for Primary Care Provider or for Specialist per office visit. Covered person pays 20% after Deductible for non-laboratory and non-x-ray services. See Policy for details.	**Inpatient Care** or **Outpatient Care** - Covered person 40% after Deductible. See Policy for details.	Covered person pays 15% after deductible.	Not covered
HOME HEALTH CARE	No Copayment (100% covered)	Covered person pays 40% after deductible	No coinsurance (100% covered).	Covered person pays 40% after deductible	Covered person pays 15% after deductible.	Not covered
			Up to **60** visits per calendar year in and out of network combined.		Up to 100 visits per calendar year.	
HOSPICE CARE	No Copayment (100% covered)	Covered person pays 40% after deductible	No coinsurance (100% covered).	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible
SKILLED NURSING FACILITY CARE	No Copayment (100% covered).	Covered person pays 40% after deductible.	Covered person pays 20% after deductible	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible
	Limited to 60 days per calendar year combined in and out of network.		Limited to 60 days per calendar year combined in and out of network.		Up to 100 days per calendar year In and Out-of-Network combined.	
DENTAL CARE	Dental benefits can be found on the separate Anthem Dental summary and Benefit Booklet	Dental benefits can be found on the sePPOate Anthem Dental summary and Benefit Booklet	Dental benefits can be found on the separate Anthem Dental summary and Benefit Booklet	Dental benefits can be found on the separate Anthem Dental summary and Benefit Booklet	Dental benefits can be found on the separate Anthem Dental summary and Benefit Booklet	Dental benefits can be found on the separate Anthem Dental summary and Benefit Booklet
VISION CARE	Vision benefits can be found on the separate Anthem Vision summary and Benefit Booklet.	Vision benefits can be found on the sePPOate 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	$25 per visit Copayment.	Same as in-network	$10 Copayment per office visit.	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Not covered
	Limited to 20 visits per calendar year combined with out-of-network		Limited to 20 visits per calendar year combined with out-of-network		20 visits per calendar year	

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Massage Therapy/ Acupuncture Care	$25 Copayment per visit.	Same as in-network	$10 Copayment per office visit.	Not covered	Covered person pays 15% after deductible	Not covered
	Limited to 20 visits per calendar year combined with out-of-network		Limited to 20 visits per calendar year combined.		Limited to 20 visits per calendar year	
HEARING AIDS **1.)** Benefits are covered for children up to age 18 and are supplied every 5 years, except as required by law. **2.)** Benefits are covered for adults (18+) and are supplied every 3 years, with a maximum benefit allowance of $4,000.	No Copayment (100% covered).	Covered person pays 40% after deductible.	Covered person pays 20% after deductible	Covered person pays 40% after deductible	Covered person pays 15% after deductible	Covered person pays 35% after deductible
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	Retail Health Clinic: $25 Copayment per visit. BlueCares for You Program	Point of Service Rider 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.	Retail Health Clinic -Covered person pays 20% after deductible Nutritional Counseling (other than for eating disorders and Diabetes Management) - Covered person pays 20% after deductible per visit for Specialist. Up to 4 visits per calendar year. Nutritional Counseling for eating disorders - Covered under Mental Health Care. Nutritional Counseling for Diabetes Management - 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.		Retail Health Clinic: Covered person pays 15% after Deductible. Nutritional Counseling (other than for eating disorders and Diabetes Management) - Covered person pays 15% after Deductible. Up to 4 visits per calendar year. Nutritional Counseling for eating disorders – Covered under Mental Health care. Nutritional Counseling for Diabetes Management – Benefit level determined by place of service.	Retail Health Clinic: Not covered Nutritional Counseling (other than for eating disorders and Diabetes Management) - Not covered Nutritional Counseling for eating disorders – Covered under Mental Health care. Nutritional Counseling for Diabetes Management – Benefit level determined by place of service.

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PRESCRIPTION DRUGS **Level of coverage and restrictions on prescriptions**[6]						
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	
b) Outpatient care	**Retail Pharmacy Drugs** Tier 1 $10 Copayment Tier 2 20% coinsuranxce (max $60) Tier 3 30% coinsurance (max $120) Tier 4 20% coinsurance up to $175 max Tier 5 30% coinsurance up to $300 max Per prescription at a participating pharmacy up to a 30-day supply.	Not covered	**Retail Pharmacy Drugs** Tier 1 $10 Copayment Tier 2 20% coinsuranxce (max $60) Tier 3 30% coinsurance (max $120) Tier 4 20% coinsurance up to $175 max Tier 5 30% coinsurance up to $300 max Per prescription at a participating pharmacy up to a 30-day supply.	Not covered	**Retail Pharmacy Drugs** - Covered person pays 15% after deductible for up to a 30-day supply.	**Retail Pharmacy Drug**s - Covered person pays 35% after deductible for up to a 30-day supply.
	PreventiveRx Drugs Tier 1 $5 Copayment (retail); $12.50 (home delivery) Tier 2 $25 Copayment (retail; $62.50 Copayment (home delivery) Tier 3 $50 Copayment (retail); $125 Copayment (home delivery)	Not covered	**PreventiveRx Drugs** Tier 1 $5 Copayment (retail); $12.50 (home delivery) Tier 2 $25 Copayment (retail; $62.50 Copayment (home delivery) Tier 3 $50 Copayment (retail); $125 Copayment (home delivery)	Not covered	**PreventiveRx Drugs** Tier 1 $5 Copayment (retail); $12.50 (home delivery) Tier 2 $25 Copayment (retail; $62.50 Copayment (home delivery) Tier 3 $50 Copayment (retail); $125 Copayment (home delivery)	

	Specialty Pharmacy Drugs - Tier 1 $10 Copayment Tier 2 20% coinsuranxce (max $60) Tier 3 30% coinsurance (max $120) Tier 4 20% coinsurance up to $175 max Tier 5 30% coinsurance up to $300 max Per prescription from our Specialty Pharmacy up to a 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 $10 Copayment Tier 2 20% coinsuranxce (max $60) Tier 3 30% coinsurance (max $120) Tier 4 20% coinsurance up to $175 max Tier 5 30% coinsurance up to $300 max Per prescription from our Specialty Pharmacy up to a 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** - Covered person pays 15% 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 are only available through The Pharmacy Benefit Manager (PBM).	**Specialty Pharmacy Drugs** - Not covered
c) Home Delivery Pharmacy Drugs	**Home Delivery Pharmacy Drugs** - Tier 1 $25 Copayment Tier 2 20% coinsuranxce (max $150) Tier 3 30% coinsurance (max $300) Tier 4 20% coinsurance up to $175 max (per 30-day supply) Tier 5 30% coinsurance up to $300 max (per 30-day supply) 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 $150) Tier 3 30% coinsurance (max $300) Tier 4 20% coinsurance up to $175 max (per 30-day supply) Tier 5 30% coinsurance up to $300 max (per 30-day supply) 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 Drug**s - 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	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. **May be covered under PreventiveRx Tier 1 cost shares.** **Retail Pharmacy or Home Delivery 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 policy. For drugs on Our approved list, call member services at 800-542-9402.	

Marathon Health	Marathon Health is a provider of primary care services that has recently become available to CHEIBA members who reside in the areas where Marathon clinics are established. Members in these locations may select a Marathon physician as their Primary Care Provider (PCP). Please contact your Employer or Customer Service for additional details.

PART C: LIMITATIONS AND EXCLUSIONS

	BlueAdvantage HMO/Point-of-Service (POS)	**PRIME Blue Priority PPO Plan**	**2500 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**	**2500 HDHP-PPO Plan**	
Network Tiering	**Tier 1** = **HMO** **Tier 2** = **PAR** (PPO Participating) Providers are unable to balance bill **Tier 3** - **OON** (Out of Network) Providers may balance bill	**Tier 1** = **Designated** **Tier 2** = **PAR** (PPO Participating) Providers are unable to balance bill **Tier 3** - **OON** (Out of Network) Providers may balance bill	N/A	
Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No	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, 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?	Per CAA: Prohibits providers from balance billing except in limited circumstances with patient notice and consent.			
What is the main customer service number?	800-542-9402			
Whom do I write/call if I have a complaint?	Write to: Anthem Blue Cross and Blue Shield Member Services Department P.O. Box 17549 Denver, CO 80217-05489			
Whom do I write/call if I want to file an Appeal or grievance?[8]	Write to: Anthem Blue Cross and Blue Shield Attn: Grievance and Appeals Department 700 Broadway Denver, CO 80273			
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			
Does the plan have a binding arbitration clause?	Yes	Yes	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 "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.

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.