Schedule of Benefits (Who Pays What)
Anthem Blue Cross and Blue Shield
Name of Carrier
BlueClassic for Group
Name of Plan
25-1000/3500- 80%
15/50/70/30%
With DXL/ER

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. Coverage for benefits shall meet or exceed those required by applicable law, which may change from time to time. 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	**OUT-OF-NETWORK**
4. DEDUCTIBLE TYPE[2]	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE[2a] **a) Individual[2b]** **b) Family[2c]**	 $1,000, excludes Copayments $3,000, excludes Copayments One Member may not contribute any more than the individual Deductible towards the family Deductible. Some Covered Services have a maximum benefit of days, visits or dollar amounts allowed. When the Deductible is applied to a Covered Service which has a maximum benefit 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.	 $3,000, excludes Copayments $9,000, excludes Copayments One Member may not contribute any more than the individual Deductible towards the family Deductible. Some Covered Services have a maximum benefit of days, visits or dollar amounts allowed. When the Deductible is applied to a Covered Service which has a maximum benefit 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.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

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	OUT-OF-NETWORK
5. OUT-OF-POCKET ANNUAL MAXIMUM[3]		
a) Individual	$3,500 Copayments, Deductible and Coinsurance are included in the Out-of-Pocket Annual Maximum.	$10,500 Copayments, Deductible and Coinsurance are included in the Out-of-Pocket Annual Maximum.
b) Family	$7,000 Copayments, Deductible 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.	$21,000 Copayments, Deductible 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?	Yes Some Covered Services have a maximum benefit of days, visits or dollar amounts allowed. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied.	Yes Some Covered Services have a maximum benefit of days, visits or dollar amounts allowed. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied. 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, you 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.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum for most Covered Services.	No lifetime maximum for most Covered Services.
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 Services.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my Primary Care Provider?	Yes	Yes

	IN-NETWORK	OUT-OF-NETWORK
8. MEDICAL OFFICE VISITS[4]		
a) Primary Care Providers	$25 Copayment per office visit which includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services.	You pay 50% after Deductible
b) Specialists	$50 Copayment per office visit which includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services.	You pay 50% after Deductible
9. PREVENTIVE CARE		
a) Children's services	No Copayment (100% covered)	You pay 50% after Deductible
b) Adult's services	No Copayment (100% covered)	You pay 50% after Deductible
10. MATERNITY		
a) Prenatal care	$50 Copayment for services from a Primary Care Provider or $50 Copayment for services from a Specialist, for first prenatal care office visit/delivery from the Doctor. Copayment includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services.	You pay 50% after Deductible for prenatal care office visits/delivery from the Doctor
b) Delivery & inpatient well baby care[5]	You pay 20% after Deductible	You pay 50% after Deductible
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** - Tier 1 $15 Copayment, tier 2 $50 Copayment, tier 3 $70 Copayment, tier 4 30% Copayment, per prescription up to a 30-day supply. For tier 4 Retail Pharmacy Drugs, the maximum Copayment per prescription is $350 per 30-day supply. Tier 1, tier 2 and tier 3 non-specialty Maintenance Medications may be filled up to a 90-day supply at a Maintenance Pharmacy. You are required to pay a Retail Pharmacy Copayment for each 30-day supply. **Outpatient Care Specialty**	**Inpatient Care** - Included with the inpatient Hospital benefit (see line 12). **Outpatient Care Retail Pharmacy Drugs** - Not covered **Outpatient Care Specialty Pharmacy Drugs -** Not covered

	IN-NETWORK	OUT-OF-NETWORK
	Pharmacy - Tier 1 $15 Copayment, tier 2 $50 Copayment, tier 3 $70 Copayment, tier 4 30% Copayment, per prescription up to a 30-day supply. For tier 4 Specialty Pharmacy Drugs the maximum Copayment per prescription is $350 per 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** - Tier 1 $37.50 Copayment, tier 2 $150 Copayment, tier 3 $210 Copayment, per prescription up to a 90-day supply. Specialty pharmacy drugs are not available through the Home Delivery Pharmacy.	**Outpatient Care Home Delivery Pharmacy Drugs -** Not covered
12. INPATIENT HOSPITAL	You pay 20% after Deductible	You pay 50% after Deductible
13. OUTPATIENT / AMBULATORY SURGERY AT A FACILITY	You pay 20% after Deductible. You pay no Deductible or Coinsurance (100% covered) for laboratory and x-ray services except for MRI, CT, PET scans, nuclear medicine and other high-tech services which are covered at 20% after Deductible.	You pay 50% after Deductible
14. DIAGNOSTICS **a) Laboratory & x-ray**	You pay no Deductible or Coinsurance (100% covered)	You pay 50% after Deductible
b) MRI, nuclear medicine, and other high-tech services	You pay 20% after Deductible	You pay 50% after Deductible
15. EMERGENCY CARE[7]	$400 Copayment per visit. Copayment is waived if admitted. You pay no Deductible or Coinsurance (100% covered) for all other services except for MRI, CT, PET scans, nuclear medicine and other high-tech services. For MRI, CT, PET scans, nuclear medicine and other high-tech services you pay 20% after Deductible.	Out-of-Network care is paid as In-Network
16. AMBULANCE	You pay 20% after Deductible	Out-of-Network care is paid as In-Network; non-emergency ambulance services will be limited to a maximum benefit of $50,000 per occurrence.

	IN-NETWORK	OUT-OF-NETWORK
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$50 Copayment per visit which includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services.	You pay 50% after Deductible
18. MENTAL HEALTH CARE **a) Inpatient care** **b) Outpatient care**	You pay 20% after Deductible For outpatient facility services, you pay 20% after Deductible; for outpatient office visits and professional services, you pay $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.	You pay 50% after Deductible You pay 50% after Deductible 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	**Inpatient Care** - You pay 20% after Deductible **Outpatient Care** - For outpatient facility services, you pay 20% after Deductible; for outpatient office visits and professional services, you pay $25 Copayment per visit.	**Inpatient Care** - You pay 50% after Deductible **Outpatient Care** - You pay 50% after Deductible
20. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	**Inpatient Care** - Included with the inpatient Hospital benefit (see line 12). Up to 30 inpatient rehab days per calendar year In and Out-of-Network combined. **Outpatient Care** - You pay 20% after Deductible. Up to 20 visits each for physical, occupational and speech therapy per calendar year In and Out-of-Network combined. From birth until the Your sixth birthday, benefits are provided as required by applicable law.	**Inpatient Care** - Included with the inpatient Hospital benefit (see line 12). Up to 30 inpatient rehab days per calendar year In and Out-of-Network combined. **Outpatient Care** - You pay 50% after Deductible**.** Up to 20 visits each for physical, occupational and speech therapy per calendar year In and Out-of-Network combined. From birth until the Your sixth birthday benefits are provided as required by applicable law.
21. DURABLE MEDICAL EQUIPMENT	You pay 20% after Deductible	Not covered
22. OXYGEN	You pay 20% after Deductible	Not covered

	IN-NETWORK	OUT-OF-NETWORK
23. ORGAN TRANSPLANTS	**Inpatient Care** - You pay 20% after Deductible **Outpatient Care** - $25 Copayment per office visit for services from a Primary Care Provider or $50 Copayment per office visit for services from a Specialist. Copayment includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services. 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.	**Inpatient Care** - Not covered **Outpatient Care** - Not covered
24. HOME HEALTH CARE	You pay 20% after Deductible. Up to 100 visits per calendar year.	Not covered
25. HOSPICE CARE	**Inpatient Care** - You pay no Deductible or Coinsurance **Outpatient Care** - You pay no Deductible or Coinsurance	**Inpatient Care** - You pay 50% after Deductible **Outpatient Care** - You pay 50% after Deductible
26. SKILLED NURSING FACILITY CARE	You pay 20% after Deductible. Up to 100 days per calendar year In and Out-of-Network combined.	You pay 50% after Deductible. Up to 100 days per calendar year In and Out-of-Network combined.
27. DENTAL CARE	Not covered	Not covered
28. VISION CARE	Not covered	Not covered
29. CHIROPRACTIC THERAPY	$25 Copayment per office visit which includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services. Up to 20 visits per calendar year, regardless of which type of Provider renders the therapy.	Not covered
30. SIGNIFICANT ADDITIONAL COVERED SERVICES	**Retail Health Clinic** $25 Copayment per office visit which includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services. **Other Covered Services** • **Massage Therapy -** $25 Copayment per office visit. Up to	**Retail Health Clinic** Not covered **Other Covered Services** • **Massage Therapy -** Not covered

	IN-NETWORK	OUT-OF-NETWORK
	20 visits per calendar year combined for massage and acupuncture therapy, regardless of which type of Provider renders the therapy. • **Acupuncture/Nerve Pathway Therapy -** $25 Copayment per office visit which includes all outpatient laboratory and x-ray services performed. You pay 20% after Deductible for all other services, including MRI, CT, PET scans, nuclear medicine and other high-tech services. Up to 20 visits per calendar year combined for massage and acupuncture therapy, regardless of which type of Provider renders the therapy. • **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.	• **Acupuncture/Nerve Pathway Therapy -** Not covered • **Nutritional Counseling (other than for eating disorders and Diabetes Management) -** Not covered • **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 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.	**Hearing Aids** 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.
	Applied Behavioral Analysis Services Benefits are based on the setting in which Covered Services are received.	**Applied Behavioral Analysis Services** Benefits are based on the setting in which Covered Services are received.
	General Information For outpatient Covered Service not elsewhere listed, you pay 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.	**General Information** For outpatient Covered Service not elsewhere listed, you pay 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.

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	**OUT-OF-NETWORK**
35. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	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.	Yes, you are responsible for obtaining 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	Yes, you will be responsible for paying the difference between the Maximum Allowed Amount and the Non-Participating Provider's Billed Charges (sometimes called "balance billing"). The amounts you pay for Out-of-Network Covered Services are in addition to your balance billing costs.
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?	Anthem Blue Cross and Blue Shield 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 COLGPPONGF 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.

NOTICE OF
PROTECTION PROVIDED BY
LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

This notice provides a **brief summary** of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website www.colifega.org, email jwrhodesifega.org or contact:

Colorado Life and Health Insurance Protection Association 201 Robert S. Kerr Ave. Suite 600 Oklahoma City, OK 73102 1-800-337-7796	*Colorado Division of Insurance* 1560 Broadway, Suite 850 Denver, CO 80202 (303) 894-7499

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.