Colorado Community College System
Blue Priority 1 15-200-80%
$150D-15/40/60/30%

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Health maintenance organization (HMO)
2. OUT-OF-NETWORK CARE COVERED?[1]	Only for Emergency and Urgent Care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Elbert, Fremont, Jefferson, La Plata, Montezuma, Pueblo, Summit and Teller counties.

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. Coverage for benefits shall meet or exceed those required by applicable insurance law, which may change from time to time. 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 Provider, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK ONLY (OUT-OF-NETWORK CARE IS NOT COVERED EXCEPT AS NOTED)
4. DEDUCTIBLE TYPE[2]	Benefit Year
4a. ANNUAL DEDUCTIBLE[2a]	
a) Individual[2b]	$1,000
b) Family[2c]	$3,000 Plus separate $150 Deductible per individual or $300 per family for outpatient tier 2 and tier 3 Prescription Drugs 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.

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5. OUT-OF-POCKET ANNUAL MAXIMUM[3]	
a) Individual	$3,000, 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.
c) Is deductible included in the out-of-pocket maximum?	Yes Some Covered Services have a maximum benefit of days, visits or dollar amounts. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum for most Covered Services. Infertility diagnostic services have a lifetime maximum benefit of $2,000 per Member.
7A. COVERED PROVIDERS	Blue Priority network, which does not include all Providers in the HMO Colorado managed care network. See Provider directory for complete list of current Providers.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my Primary Care Provider?	Yes
8. MEDICAL OFFICE VISITS[4]	
a) Primary Care Providers	$15 Copayment per visit. For laboratory and x-ray services see line 14 for payment information.
b) Specialists	$45 Copayment per visit. For laboratory and x-ray services see line 14 for payment information.
9. PREVENTIVE CARE	
a) Children's services to age 13	No Copayment (100% covered)
b) Adults' services	No Copayment (100% covered) Covered preventive care services include those that meet the requirements of federal and state law including certain screenings, immunizations, contraceptives and office visits.
10. MATERNITY	
a) Prenatal care	$100 global Copayment for prenatal care office visit/delivery from the Doctor. For laboratory and x-ray services see line 14 for payment information.
b) Delivery & inpatient well baby care[5]	$200 Copayment per admission then you pay 20% after Deductible
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions[6]	**Inpatient care** - Included with the inpatient Hospital benefit (see line 12). **Tier 2 and tier 3 outpatient Retail Pharmacy, Specialty Pharmacy and/or Home Delivery Prescription Drugs are first subject to a Deductible, once satisfied then services are subject to the Copayment per prescription.**

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	Outpatient care - **Retail Pharmacy Drugs** - Tier 1 $15 Copayment, tier 2 $40 Copayment, tier 3 $60 Copayment, tier 4 30% Copayment, per prescription at a participating pharmacy up to a 30-day supply. For tier 4 Retail Pharmacy drugs, the maximum Copayment per prescription is $250 per 30-day supply. **Outpatient care** - **Specialty Pharmacy Drugs** - Tier 1 $15 Copayment, tier 2 $40 Copayment, tier 3 $60 Copayment, tier 4 30% Copayment, per prescription from Our Specialty Pharmacy up to a 30-day supply. For tier 4 Specialty Pharmacy Drugs the maximum Copayment per prescription is $250 per 30-day supply from Our Specialty Pharmacy. Specialty Pharmacy Drugs are not available at a Retail Pharmacy or from a Home Delivery Pharmacy. **Outpatient care** - **Home Delivery Pharmacy Drugs** - Tier 1 $15 Copayment, tier 2 $80 Copayment, tier 3 $120 Copayment, tier 4 30% Copayment, per prescription through the Home Delivery Pharmacy up to a 90-day supply. For the tier 4 Home Delivery Pharmacy drugs, the maximum Copayment per prescription is $250 per 30-day supply or $500 per 90-day supply. Specialty Pharmacy Drugs are not available through the Home Delivery Pharmacy. 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 costs. You may request, or your Provider may order, the Brand-Name Drug. However, if a Generic Drug is available, you will need to pay for the cost difference between the Generic and Brand Name Drug, in addition to your tier Copayment. The cost difference between the Generic and Brand Name Drug does not go towards your Out-of-Pocket Annual Maximum. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. We reserve the right, at Our discretion, to remove certain higher cost Generic Drugs from this coverage. For drugs on Our approved list, call member services at 877-811-3106.
12. INPATIENT HOSPITAL	$200 Copayment per admission then you pay 20% after Deductible
13. OUTPATIENT / AMBULATORY SURGERY AT A FACILITY	$200 Copayment per admission at an ambulatory surgery center. $200 Copayment per admission then you pay 20% after Deductible at a Hospital.

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14. DIAGNOSTICS **a) Laboratory & x-ray**	No Copayment (100% covered) for laboratory services except those services received from either a Hospital or Hospital-based Provider. You pay a $45 Copayment per visit for x-ray services except those services received from either a Hospital or Hospital-based Provider. $200 Copayment per visit then you pay 20% after Deductible for laboratory and x-ray services received from either a Hospital or Hospital-based Provider.
b) MRI, nuclear medicine, and other high-tech services	$200 Copayment per procedure for MRI/MRA/CT/PET scans except those services received from either a Hospital or Hospital-based Provider. $200 Copayment per procedure then you pay 20% after Deductible for MRI/MRA/CT/PET scans received from either a Hospital or Hospital-based Provider.
15. EMERGENCY CARE[7]	$200 Copayment per Emergency room visit. Copayment is waived if admitted. Care is covered In or Out-of-Network.
16. AMBULANCE	You pay 20% after Deductible. Care is covered In or Out-of-Network.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	$45 Copayment per visit. For laboratory and x-ray services see line 14 for payment information. Urgent care may be received from your PCP or from an Urgent Care center. Care is covered In or Out-of-Network.
18. MENTAL HEALTH CARE	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.
a) Inpatient care	$200 Copayment per admission then you pay 20% after Deductible
b) Outpatient care	For outpatient facility services, you pay 20% after Deductible; for outpatient office visits and professional services $15 Copayment per visit.
19. ALCOHOL & SUBSTANCE ABUSE	**Inpatient Care** - $200 Copayment per admission then you pay 20% after Deductible **Outpatient Care** - For outpatient facility services, you pay 20% after Deductible; for outpatient office visits and professional services $15 Copayment per visit.
20. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY	**Inpatient Care -** $200 Copayment per admission then you pay 20% after Deductible. Up to 30 inpatient rehab days per benefit year. **Outpatient Care -** $15 Copayment per visit. For laboratory and x-ray services see line 14 for payment information. Up to 20 visits each for physical, occupational or speech therapy per benefit year. From birth until the Member's sixth birthday, benefits are provided as required by applicable law.
21. DURABLE MEDICAL EQUIPMENT	You pay 50% after Deductible
22. OXYGEN	You pay 50% after Deductible

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23. ORGAN TRANSPLANTS	**Inpatient care -** $200 Copayment per admission then you pay 20% after Deductible. **Outpatient care -** $15 Copayment per visit for PCP, $45 Copayment per visit for Specialist. For laboratory and x-ray services see line 14 for payment information. Transportation and lodging services are limited to a maximum benefit of $10,000 per Transplant Benefit Period; unrelated donor searches are limited to a maximum benefit of $30,000 per Transplant Benefit Period.
24. HOME HEALTH CARE	You pay 20% after Deductible. Up to 100 visits per benefit year.
25. HOSPICE CARE	No Copayment (100% covered)
26. SKILLED NURSING FACILITY CARE	You pay 20% after Deductible. Up to 100 days per benefit year.
27. DENTAL CARE	Not covered
28. VISION CARE	Vision benefits can be found on the separate Anthem Vision summary and Benefit Booklet
29. CHIROPRACTIC THERAPY	$20 Copayment per visit. For laboratory and x-ray services see line 14 for payment information. Up to 20 visits per benefit year combined with massage therapy and acupuncture/nerve pathway therapy.
30. SIGNIFICANT ADDITIONAL COVERED SERVICES	**Retail Health Clinic** $30 Copayment per visit. For laboratory and x-ray services see line 14 for payment information. **Other Covered Services** o **Massage Therapy, Acupuncture/Nerve Pathway Therapy -** $20 Copayment per visit. For laboratory and x-ray services see line 14 for payment information. Up to 20 visits per benefit year combined with chiropractic care. o **Nutritional (other than for eating disorders and Diabetes Management) -** $20 Copayment per visit for Specialist. Up to 4 visits per benefit year. o **Osteopathic manipulative therapy (OMT)** – subject to office visit Copayment, up to a maximum of 6 outpatient visits per benefit year. o **Nutritional Counseling for eating disorder** – covered under Mental Health Care, please see row 19. o **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 and are supplied every 5 years, except as required by law. **Treatment of Autism Spectrum Disorders** Benefit level determined by type of service provided. The following annual maximums, based on benefit year, are effective for applied behavior analysis services. We may exceed these maximums if required by law: o From birth to age eight (up to Member's ninth birthday): 550 sessions of 25 minutes for each session

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	o Age nine to age eighteen (up to Member's nineteenth birthday): 185 sessions of 25 minutes for each session **General Information** For any outpatient Covered Service not elsewhere listed, you pay Coinsurance after Deductible. For example this includes chemotherapy and outpatient non-surgical facility services. However, some outpatient Covered Services received from a Hospital may require a $200 Copayment prior to and in addition to the Deductible and 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
35. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	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.
36. 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.
37. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No
38. What is the main member service number?	877-811-3106
39. Whom do I write/call if I have a complaint or want to file a grievance?[8]	HMO Colorado, Complaints and Appeals 700 Broadway Denver, CO 80273 877-811-3106
40. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202
41. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form #'s COLGHMONGF Large Group
42. Does the plan have a binding arbitration clause?	Yes

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

[2] "Deductible Type" indicates whether the deductible period is "Benefit 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 deducible 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 benefit 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 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 layperson 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.

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

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

The information above is only a summary of the benefits described. The Booklet includes important additional information about limitations, exclusions and covered benefits. The Schedule of Benefits (Who Pays What) 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.