HEALTH INSURANCE

BlueAdvantage Point-of-Service Plan (HMO/POS)  Prime Health Plan (PPO)
Health Choices Comparison  Custom Health Plan

The CHEIBA Trust is pleased to continue to offer you three health insurance plans with Anthem Blue Cross and Blue Shield. Part of Anthem’s mission is to provide useful tools that help improve the lives of their members and assist them in making informed decisions about their health and are included with your health coverage.

MyAnthem™

Tired of paperwork and phone calls? MyAnthem™ takes the hassle out of your health care. Get your information when you need it. Access your health plan services online through the secure MyAnthem™ site at www.anthem.com, Colorado, MyAnthem login. Use MyAnthem™ to:

✓ Find a doctor or hospital
✓ Order a new ID card or print a temporary ID card
✓ View your benefits or check on a claim
✓ Change your address or primary care physician
✓ See if your medication is on the Anthem formulary
✓ Visit MyHealth@Anthem®, powered by WebMD®, for personalized health information, surveys and calculators
✓ Save money on health-related products and services with SpecialOffers@Anthem™
✓ Get help making medical choices with decision-support tools

360ºHealth

Introducing Anthem Blue Cross and Blue Shield’s 360ºHealth program. Listed below are some of the key resources:

⊙ ConditionCare
If you or one of your dependents have diabetes, coronary artery disease (CAD), heart failure (HF), chronic obstructive pulmonary disease (COPD) or asthma, ask Anthem about our programs to help manage these conditions. ConditionCare is included in your health plans and offers valuable tools and information that could make a real difference as you strive for better health.

阃 24-hour, toll-free access to registered nurses to answer your questions and provide you with support and education on how to better manage your condition
阃 Specially designed condition-specific care diaries, self-monitoring charts, self-care tips and other easy-to-use empowerment materials.

For information about Anthem’s ConditionCare programs, call toll-free 877-236-7486 or go to www.anthem.com and select Healthy Lifestyles. Various conditions are listed for your information.

⊙ Future Moms
The program, Future Moms, is there for our moms-to-be. At such an important time in your life, you’ll have access to extra pre- and post-natal, confidential support and education any time of
the day or night! Even with terrific care from your doctor, you may have questions that come up between visits. Nurses are available for you to talk with around the clock. You may also benefit from:

- Maternity care materials including *Your Pregnancy Week By Week*, which is a helpful prenatal care book
- A confidential questionnaire to evaluate your risk for premature delivery
- Useful tools to help you, your doctor and your **Future Moms** nurse track your pregnancy and identify possible risks

Anthem’s goal is to help you and your doctor work together to have a healthy pregnancy and a healthy new baby. Remember, your doctor is your best source of information about your pregnancy and your health, and Future Moms is here to help along the way.

To reach Future Moms, call toll-free 866-664-5404 or go to [www.anthem.com](http://www.anthem.com) and select Healthy Lifestyles.

**24/7 NurseLine**

Whether it’s 3 p.m. or 3 a.m., wouldn’t it be great if you could speak with an experienced nurse about any of your health questions or issues? Now you can!

The **24/7 NurseLine** can assist you in making more informed health care decisions via confidential, one-on-one conversations with a registered nurse, any time of the day or night. Whenever you call, you can easily access a library of audio tapes on a range of topics related to your health care. Or, if you prefer, you can talk to a nurse about hundreds of health issues ranging from asthma to zinc, like: Coughs • Abdominal Pain • Weight Loss • Colds • Children’s Health • Sexually Transmitted Diseases • Fever • Food & Diet • Headache • Smoking • Women’s Health. . . and much more! Bilingual nurses, the Language Line and TTY/TDD relay services for the hearing impaired are also available.

For confidential health information from a registered nurse 24-hours a day, 365 days a year, call 1-800-337-4770 or go to [www.anthem.com](http://www.anthem.com) and select Healthy Lifestyles.

**24/7 NurseLine** is not an emergency response system. In a medical emergency, call 911 or your local emergency service number.

The CHEIBA Trust offers you three health insurance plans from which to select. All three choices are open to all benefit-eligible Employees and their Dependents. Please review the Colorado Health Plan Description Form located in the pocket of this booklet regarding the various health insurance plans carefully before you make your selection. After you enroll you will receive your membership card. It will be mailed to your home. If you do not receive your card, call the Customer Service number as noted on the Phone Reference Page at the beginning of this book.
Choices include:

- BlueAdvantage Point-of-Service Plan (HMO/POS)
  (Health Maintenance Organization, HMO)
- PRIME Health Plan
  (Preferred Provider Organization, PPO)
- Custom Plus Health Plan (closed to new enrollment effective January 1, 2010)
  (Major Medical Plan)

Premium Payments
To assist in reducing your insurance premium costs, your share of health insurance premiums can be paid with pre-tax dollars under the CHEIBA Trust Pre-Tax Insurance Premium Payments Account under the Flexible Benefit Plan. If you and your spouse both work within the CHEIBA Trust system and choose the Dependent coverage option, you may choose to have one spouse pay for all premiums. If you and your spouse both work within the CHEIBA Trust system and Dependent coverage is not selected, you should enroll separately to maximize premium savings.

For Premium Payments involving Domestic Partners and the children of Domestic Partners, please review the document entitled, “Important Tax Information for Domestic Partner Health and Dental Benefits”.

NOTE: If you are a Participant in PERA and are within three years of retirement, you may want to elect to pay your premiums with after-tax dollars to ensure your highest possible PERA benefit in retirement. PERA retirement benefits are based on your highest paid three years of employment.

- BlueAdvantage Point-of-Service (HMO/POS)

This choice is the Point-of-Service (HMO/POS) Plan which includes both in-network and out-of-network benefits. In-network benefits are available to all locations except Gunnison. A member has the option for both in-network and out-of-network benefits based on the provider rendering the service.

Physician Selection
Under the HMO/POS Plan, you must select a primary care physician (PCP) for yourself and each covered Dependent in order to be eligible for in-network benefits. Members are not required to obtain a referral from their PCP to see an in-network specialist. However, Anthem does encourage you to ask your PCP for an in-network referral recommendation.

If you experience a medical emergency, you may seek help at any facility and benefits will be based on in-network benefits.

Services rendered by a non-HMO provider are processed out-of-network and are subject to the appropriate deductible and coinsurance. This option is designed to give members the choice of receiving covered services outside the regular HMO Colorado Plan requirements. For services under this portion of the plan, the member does not need a PCP referral for services. A member can receive covered services from any provider whether or not they are within the HMO Colorado network of providers and benefits will be based on in-network for HMO or POS for out-of-network. Many of these services require prior authorization before services are rendered.

Additionally, out-of-network services may be subject to Balance Billing. If you have any questions regarding out-of-network services, please read the plan description carefully or call for assistance.
BlueAdvantage Point-of-Service (HMO/POS) Comparison

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<tr>
<td>Office Visit Copayments</td>
<td>$15 Copayment</td>
<td>70% after deductible (based on usual, customary &amp; reasonable fees)</td>
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**Deductibles and Copayments**

In-network there are no deductibles. When services are rendered by an HMO provider there is a $15 copayment per visit and unlimited lifetime benefits.

Out-of-network there is a $500 individual deductible and a $1,000 family deductible. These deductibles apply when services are rendered by a non-HMO provider. Your maximum out-of-pocket expenses for these services are $2,500 plus deductible for the individual and $5,000 plus deductible for family.

**Prescription Drug Benefit**

Your ID Card is your membership card for both doctor visits and prescriptions. The prescription drug benefit is provided through WellPoint NextRx and includes a formulary plan with four tiers. The formulary includes prescription drugs that have been approved for use by HMO Colorado and is updated on a quarterly basis. You can review this formulary by going to www.anthem.com.

The prescription copayments for up to a 30-day supply when filled by a WellPoint NextRx pharmacy will be as follows:
- Tier 1 - $15 copayment
- Tier 2 - $30 copayment
- Tier 3 - $45 copayment
- Tier 4 – The lesser of 30% or $100 copayment per prescription drug

Diabetic supplies/prescriptions and asthma inhalers/prescriptions will be covered under Tier 1.

The prescription copayments for up to a 90-day supply when filled through the mail order program will be as follows:
- Tier 1 - $30 copayment
- Tier 2 - $60 copayment
- Tier 3 - $90 copayment
- Tier 4 – The lesser of 30% or $200 copayment per prescription drug

Prescription drugs purchased from out-of-network providers are not covered.

**NOTE:** Always ask for a Tier 1 drug, if available, to ensure your highest possible benefit. When there is no Tier 1 drug available, the member will pay the higher tier copayment. **If the member chooses a Tier 2 or Tier 3 drug when a Tier 1 drug is available, the copayment of $30 or $45 (if mail order the copayment is $60 or $90) plus the difference in price between the Tier 1 and Tier 2 or Tier 3 drug will apply.** Services, supplies and prescriptions for the treatment of sexual dysfunction are not covered.

Specialty drugs must be ordered through PrecisionRx Specialty Solutions, which offers a full-service pharmacy that ships medications to members or their provider, up to a 30-day supply, by overnight mail or common carrier.
Well Care Visits
Preventive services are covered on an in-network basis when provided by your PCP.

Additional well care services include: prostate examinations, annual GYN exams, family planning services and pediatric and adult immunizations. When rendered by a non-HMO provider, some of the above services are not covered.

Routine Preventive Colonoscopies
Routine colonoscopies are covered under a separate wellness benefit with no age limit and no frequency limit. In-network treatment is covered at 100% of allowed amount with no copayment. Out-of-network treatment is not subject to deductible but is subject to coinsurance. Please refer to the Colorado Health Benefit Plan Description Form.

Nervous/Mental Illness and Alcohol/Substance Abuse Care
These services must be pre-authorized by the HMO Colorado behavioral health administrator prior to receiving services. These services are - covered as any other medical condition.

Hospital Admission
A $400 copayment applies to in-network hospital admissions, and the HMO Colorado Plan will cover your non-emergency inpatient hospital stay when you are admitted by your PCP, or by a PCP referred specialist, to an HMO Colorado-approved hospital. Hospital services that are referred by a non-HMO physician and/or performed at a non-HMO hospital are subject to out-of-network deductibles and coinsurance.

Outpatient / Ambulatory Surgery
A $75 copayment applies to HMO in-network outpatient / ambulatory surgery.

Outpatient Lab
Outpatient lab services at an HMO in-network provider will have a separate $100 copayment for the following lab tests: MRI, MRA, CT, and PET scans.

Emergency Care
When you require immediate medical services , you will be covered at in-network benefits whether you are within or outside the HMO Colorado service area. Emergency care is defined as care that is needed, or appears to be needed, immediately, to prevent the death of the member or a serious impairment of the member’s health. See your HMO Colorado Plan Booklet for detailed procedures to follow in the event of a medical emergency.

The use of an emergency center for non-emergency medical care will not be covered. There is a $100 copayment for ambulance service, a $50 copayment for an urgent-care facility and a $100 copayment for a hospital emergency room. The $100 copayment for the hospital emergency room is waived if you are admitted to the hospital.

For questions, call BlueAdvantage Point-of-Service Customer Service: .......... 1-800-542-9402
Website .............................................................................................................www.anthem.com
**Prime Health Plan (PPO)**

This choice is the Preferred Provider Organization (PPO) plan which includes in and out-of-network coverage. To obtain a higher level of benefits you can select a PPO provider within the network of PPO doctors or you can choose to go outside the network and see any doctor of your choice.

**NOTE:** If you live in a rural area and there are no PPO providers within a reasonable distance from you, you may request authorization to see an out-of-network provider. Call customer service to request the authorization.

**Physician Selection**

You can select PPO physicians who have entered into an agreement with Anthem Blue Cross and Blue Shield to provide care at negotiated rates, which saves you money on coinsurance charges, or you can select the physician of your choice outside of the PPO network. However, out-of-pocket expenses may be significantly higher if you select an out-of-network provider.

**Deductibles and Coinsurance**

If you use a PPO provider a $350 individual deductible or a $700 family deductible applies annually. If you use a non-PRIME provider a $840 individual deductible or a $1,680 family deductible applies annually. For physician services, PPO provider fees are paid at 85% of the maximum benefit allowance. Non-PPO provider fees are paid at 65% of the maximum benefit allowance after the deductible has been met. When using PPO network and/or non-PPO network services, the maximum lifetime benefit is unlimited.

**Prescription Drug Benefit**

Your ID Card is your membership card for both doctor visits and prescriptions. The prescription drug benefit is provided through WellPoint NextRx and includes a formulary plan with four tiers. The formulary includes prescription drugs that have been approved for use by Anthem Blue Cross and Blue Shield and is updated on a quarterly basis. You can review this formulary by going to [www.anthem.com](http://www.anthem.com).

The prescription copayments for up to a **30-day** supply when filled by a WellPoint NextRx pharmacy will be as follows:

- Tier 1 - $15 copayment
- Tier 2 - $30 copayment
- Tier 3 - $45 copayment
- Tier 4 – The lesser of 30% or $100 copayment per prescription drug

Diabetic supplies/prescriptions and asthma inhalers/prescriptions will be covered under Tier 1.

The prescription copayments for up to a **90-day** supply when filled through the mail order program will be as follows:

- Tier 1 - $30 copayment
- Tier 2 - $60 copayment
- Tier 3 - $90 copayment
- Tier 4 – The lesser of 30% or $200 copayment per prescription drug

Prescription drugs purchased from out-of-network providers are not covered.

**NOTE:** Always ask for a Tier 1 drug, if available, to ensure your highest possible benefit. When there is no Tier 1 drug available, the member will pay the higher tier 2 copayment. If the member chooses a Tier 2 or Tier 3 drug when a Tier 1 drug is available, the copayment of $30 or $45 (if mail order the copayment is $60 or $90) plus the difference in price between
the Tier 1 and Tier 2 or Tier 3 drug will apply. Services, supplies and prescriptions for the treatment of sexual dysfunction are not covered.

Specialty drugs must be ordered through Precision Specialty Solutions, which offers a full-service pharmacy that ships medications to members or their provider, up to a 30-day supply, by overnight mail or common carrier.

Well Care Visits
Preventive care services for Eligible Dependent children are covered by either a PPO physician or a non-PPO physician, not subject to the coinsurance or deductible up to age 13.

Services for members age 13 years and older are provided a maximum benefit of $500 per member per calendar year. This includes pap smear, pelvic exam, GYN exam, related lab and x-rays and other routine exam fees.

Routine Preventive Colonoscopies
Routine colonoscopies are covered under a separate wellness benefit with no age limit and no frequency limit not subject to the $500 preventive care limit. In-network treatment is covered at 100% of allowed amount with no coinsurance or deductible. Out-of-network treatment is not subject to deductible but is subject to coinsurance. Please refer to the Colorado Health Benefit Plan Description Form.

Routine Preventive Care
Preventive care services for adults are covered either by a PPO or non-PPO physician up to $500 per member per calendar year (not subject to the deductible and coinsurance). Routine exams related to insurance, licensing, employment, school or camp are not covered. Mammograms and prostate screenings are excluded from the $500 payment maximum and are covered in full up to the maximum benefit allowance (no deductible or coinsurance). HPV-Gardasil immunizations are covered but not applied to the $500 wellness benefit maximum (deductible and coinsurance are applied).

Nervous/Mental Illness and Alcohol/Substance Abuse
These services must be pre-authorized by the PPO behavioral health administrator prior to receiving services. These services are covered as any other medical condition.

Hospital Admission
Hospital charges are covered at 85% after deductible, if you stay in a PPO hospital and 65% after deductible, if you stay in a non-PPO hospital. All non-emergency hospital admissions require pre-authorization.

Failure by you to obtain a pre-authorization when using a non-participating provider may result in denial of the hospital room expenses, regardless of the medical necessity of the admission. Participating providers in Colorado are responsible for obtaining a pre-authorization. If using a provider outside of Colorado, it is your responsibility to ensure any needed pre-authorization is obtained.

NOTE: If, unknowingly, a covered service is received from a non-participating provider while at a PPO hospital, payment is made at the in-network PPO level. You will need to contact Customer Service to have the claim reprocessed at in-network benefit levels.

Pre-authorization is a program designed to help control medical costs by encouraging the use of outpatient services whenever possible. It is our goal to ensure you receive care in the most medically-appropriate and cost-effective setting possible. Your physician may obtain pre-authorization by calling Monday through Friday between 8:30 am - 5:00 pm.
Emergency Care
Emergency Care and Urgent Care are covered as in-network benefits even if you are treated in an out-of-network facility. If your claim is processed at out-of-network benefits, contact Anthem Customer Service and request reprocessing of the claim. The facility must include the appropriate "emergency care" procedure codes in order to validate the emergency nature of the claim.

Ambulance benefits are also covered at in-network benefits, even if the ambulance provider is out of network.

For questions, call PRIME Customer Service: 1-800-542-9402
Website: www.anthem.com

CUSTOM PLUS HEALTH PLAN (closed to new enrollment effective January 1, 2010)

This choice is a traditional major medical plan.

Physician Selection
There are no restrictions regarding the choice of physicians under this plan. Please note, if you select a provider not participating in the Traditional Participating Network, you may be subject to Balance Billing.

Deductibles and Copayments
Deductibles are $600 per individual or $1,200 per family per year. Services are paid at 80% of the maximum benefit allowance after the deductible has been met. Maximum annual out-of-pocket expenses are $2,000 per individual and $4,000 per family plus the deductible. There are unlimited lifetime benefits under this plan.

Prescription Drug Benefit
Prescription drugs are covered at 80% after the deductible is met. There is no separate prescription card. Prescription benefits are reimbursed to you after you submit a medical expense claim form found on anthem.com. Claim forms are provided through Anthem Blue Cross and Blue Shield of Colorado or through your Human Resources/Benefits Office.

Well Care Visits
Preventive care services for Eligible Dependent children are covered up to age 13, not subject to the deductible or coinsurance.

Services for members age 13 years and older are provided a maximum benefit of $500 per member per calendar year. This includes pap smear, pelvic exam, GYN exam, related lab and x-rays and other routine exam fees.

Routine Preventive Colonoscopies
Routine colonoscopies are covered at 100% of allowed amount under a separate wellness benefit with no age limit, no frequency limit, no coinsurance and no deductible.

Routine Preventive Care
Preventive care services for adults are covered up to $500 per member per calendar year (not subject to the deductible and coinsurance). Routine exams related to insurance, licensing, employment, school or camp are not covered. Mammograms and prostrate screenings are excluded from the $500 payment maximum and are covered in full up to the maximum benefit
allowance (no deductible or coinsurance). HPV-Gardasil immunizations are covered but not applied to the $500 wellness benefit maximum (deductible and coinsurance are applied).

**Hospital Admission**
Pre-authorization is a program designed to help control medical costs by encouraging the use of outpatient services whenever possible. It is the goal of Anthem Blue Cross and Blue Shield of Colorado to ensure you receive care in the most medically-appropriate and cost-effective setting possible.

Hospital charges are covered at 80% after your deductible. For all hospital visits, your physician must obtain a pre-authorization, completed by your physician and submitted for review. Failure by you to obtain a pre-authorization by a non-participating physician may result in denial of the hospital room expenses, regardless of the medical necessity of the admission.

**Emergency Care**
In the event of emergency care, hospital and urgent care expenses are paid at 80% after the deductible is met.

The maximum benefit for ground ambulance is $2,000. The maximum air ambulance benefit is $5,000.

For questions, call Custom Plus Customer Service: 1-800-542-9402
Website: www.anthem.com

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**NOTE:** This is only an overview of your insurance plan choices. Review the Colorado Health Benefit Plan Description Form (back pocket of this book) and the specific certificate booklets pertaining to each plan for further details and explanations. If discrepancies are found, depend upon the policy itself for accuracy. All deductibles are based on a calendar year.

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