Anthem

Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
Colorado Individual SmartSense Full Rx 2500
Effective November 15, 2008

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. 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.

	IN-NETWORK	OUT-OF-NETWORK
4. Deductible Type[2]	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE[2a] a) Single[2b] b) Non-single[2c]	 $2,500 per individual $5,000 maximum per family Once two (2) or more members' allowable charges that applied to their individual deductible, combine to equal the family maximum deductible, no further deductible will be required for all enrolled members for the remainder of that year. However, no one person can contribute more than their individual deductible amount to the family maximum deductible.	 $5,000 per individual $10,000 maximum per family Once two (2) or more members' allowable charges that applied to their individual deductible, combine to equal the family maximum deductible, no further deductible will be required for all enrolled members for the remainder of that year. However, no one person can contribute more than their individual deductible amount to the family maximum deductible.

An independent licensee of the Blue Cross and Blue Shield Association.
Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc.
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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.

MCOCN2996A (7-08)
Z288, Z289

	IN-NETWORK	OUT-OF-NETWORK
5. OUT-OF-POCKET ANNUAL MAXIMUM a) Individual[3]	$5,000 per individual, includes deductible, copayments, and coinsurance.	$15,000 per individual, includes deductible, copayments, and coinsurance.
b) Family	$10,000 per family, includes deductible, copayments and coinsurance. Once two (2) or more members' allowable charges that applied to their individual out-of-pocket annual maximum, combine to equal the family out-of-pocket annual maximum, no further copayments or coinsurance will be required for all enrolled members for the remainder of that year. However, no one person can contribute more than their individual out-of-pocket annual maximum amount to the family out-of-pocket annual maximum.	$30,000 per family, includes deductible, copayments, and coinsurance. Once two (2) or more members' allowable charges that applied to their individual out-of-pocket annual maximum, combine to equal the family out-of-pocket annual maximum, no further copayments or coinsurance will be required for all enrolled members for the remainder of that year **except** for charges in excess of the Maximum Benefit Allowance and where specifically noted in the certificate.. However, no one person can contribute more than their individual out-of-pocket annual maximum amount to the family out-of-pocket annual maximum.
c) Is the deductible included in the out-of-pocket maximum?	Yes	Yes
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	$7,000,000 per member in- and out-of-network combined for all covered services.	$7,000,000 per member in- and out-of-network combined for all covered services.
7A. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list or current providers.	All providers licensed or certified to provide covered benefits.

	IN-NETWORK	OUT-OF-NETWORK
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes
8. MEDICAL OFFICE VISITS[4] **a) Primary Care Providers**	$30 copayment per office visit when included in the first three (3) office visits in a calendar year; then 30% coinsurance after deductible.	50% coinsurance after deductible.
b) Specialists	$30 copayment per office visit when included in the first three (3) office visits in a calendar year; then 30% coinsurance after deductible.	50% coinsurance after deductible.
9. PREVENTIVE CARE **a) Children's services**	$30 copayment per office visit when included in the first three (3) office visits in a calendar year; then 30% coinsurance after deductible for age-appropriate visits and routine immunizations (up to age 13).	50% coinsurance after deductible for age-appropriate visits and routine immunizations (up to age 13).
b) Adults' services	$30 copayment per office visit when included in the first three (3) office visits in a calendar year; then 30% coinsurance after deductible for mammogram screening and prostate screening. Colorectal cancer screening is covered and is not subject to the deductible. Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.	50% coinsurance after deductible for mammogram screening and prostate screening. Colorectal cancer screening is covered and not subject to the deductible. Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.
10. MATERNITY **a) Prenatal care**	Not covered except for complications of pregnancy.	Not covered except for complications of pregnancy.
b) Delivery & inpatient well baby care[5]	Delivery not covered. 30% coinsurance after deductible for inpatient well baby care.	Delivery not covered. 50% coinsurance after deductible for inpatient well baby care.
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions (COMPREHENSEIVE)		
a) Outpatient care	**Participating Retail Pharmacy:** **Generic Drugs:** $15 Copayment or 40% coinsurance, whichever is greater for each prescription and/or refill for a maximum thirty (30) day supply • **Brand Drugs:** 100% of allowable charge per member per calendar year until the $500 Brand Name/Specialty Prescription Drug Deductible has been satisfied. After the $500 Brand Name and /Specialty	Not covered

	IN-NETWORK	OUT-OF-NETWORK
	Prescription Drug Deductible has been satisfied: o $15 copayment or 40% coinsurance, whichever is greater, for each prescription and/or refill for a maximum thirty (30) day supply. o $15 copayment or 40% coinsurance, whichever is greater, **plus** the difference in cost between the brand name drug and the generic equivalent drug if a generic equivalent drug is available for each prescription and/or refill for a maximum thirty (30) day supply. **Specialty Pharmacy Drugs:** Specialty drugs are high-cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty drugs may have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. • **Self-Administered Injectable Drugs:** 40% coinsurance after the $500 Brand Name/Specialty Prescription Drug Deductible has been satisfied for each prescription and/or refill for a maximum thirty (30) day supply. **Note:** There is a $500 Brand Name/Specialty pharmacy drug coinsurance maximum per prescription when purchased at participating pharmacies. You will not be required to pay more than $500 for any prescription or refill for Brand Name/Specialty pharmacy drugs when they are purchased at a participating pharmacy.	
	Brand Name/Specialty Drug Copayment/Coinsurance Maximum: There is a $5000 Brand Name/Specialty Prescription Drug Copayment/Coinsurance Maximum for Prescription Drugs per member per calendar year purchased from Participating Pharmacies and through the mail order Prescription Drug program or PrecisionRx Specialty Solutions. You will not be required to pay more than $5000 per calendar year for Prescription Drugs purchased from Participating Pharmacies or through the mail order Prescription Drug program or PrecisionRx Specialty Solutions. Once the $5000 Brand Name/Specialty Prescription Drug	

	IN-NETWORK	OUT-OF-NETWORK
	Copayment/Coinsurance Maximum is met, no further Copayments or Coinsurance will be required for Participating Pharmacies or through the mail	
b) Prescription Mail Service	**Mail Order:** **Generic Drugs:** $15 copayment or 40% coinsurance, whichever is greater for each prescription and/or refill for each thirty (30) day supply or a $45 copayment or 40% coinsurance, whichever is greater, for up to a maximum ninety (90) day supply. Specialty pharmacy medications are not available through mail-order. • **Brand Drugs:** After a $500 per member per calendar year Brand Name/Specialty pharmacy drug is satisfied: $15 copayment or 40% coinsurance, whichever is greater for each prescription and/or refill for each thirty (30) day supply or a $45 Copayment or 40% coinsurance, whichever is greater, for up to a maximum ninety (90) day supply. Specialty pharmacy medications are not available through mail-order. • **Self-Administered Injectable Drugs:** 40% coinsurance after the $500 Brand Name/Specialty Prescription Drug Deductible has been satisfied for each prescription and/or refill for a maximum ninety(90) day supply Specialty pharmacy medications are not available through mail-order. Drugs obtained from pharmacies outside the United States will not be covered unless such drugs are prescribed in connection with Emergency Care.	Not covered
12. INPATIENT HOSPITAL	30% coinsurance after deductible.	50% coinsurance after deductible.
13. OUTPATIENT/AMBULATORY SURGERY	30% coinsurance after deductible.	50% coinsurance after deductible.
14. DIAGNOSTICS		
a) Laboratory & x-ray	30% coinsurance after deductible.	50% coinsurance after deductible.
b) MRI, nuclear medicine, and other high-tech services	30% coinsurance after deductible.	50% coinsurance after deductible.
15. EMERGENCY CARE[7, 8]	30% coinsurance after deductible.	30% coinsurance after deductible.
16. AMBULANCE		
a) Ground	30% coinsurance after deductible.	50% coinsurance after deductible.
b) Air	30% coinsurance after deductible.	50% coinsurance after deductible.

	IN-NETWORK	OUT-OF-NETWORK
	Ground Services ; Anthem will pay a maximum of $3,000 per calendar year, in– and out-of-network combined	Ground Services ; Anthem will pay a maximum of $3,000 per calendar year, in– and out-of-network combined
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	30% coinsurance after deductible.	50% coinsurance after deductible.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
19. 0THER MENTAL HEALTH CARE		
a) Inpatient care	30% coinsurance after deductible.	50% coinsurance after deductible.
b) Outpatient care	30% coinsurance after deductible. Anthem will cover benefits up to a maximum of forty (40) days, in- and out-of-network combined, per calendar year.	50% coinsurance after deductible. Anthem will cover benefits up to a maximum of forty (40) days, in- and out-of-network combined, per calendar year.
20. ALCOHOL & SUBSTANCE ABUSE	30% coinsurance after deductible Inpatient rehabilitation: Anthem will cover benefits up to a maximum of twenty (20) days, in- and out-of-network combined, per calendar year for inpatient rehabilitation for treatment of alcohol or drug abuse. Counseling: Anthem will pay benefits up to twenty (20) outpatient visits, in- and out-of-network combined, per calendar year for alcohol and drug abuse treatment	50% coinsurance after deductible Inpatient rehabilitation: Anthem will cover benefits up to a maximum of twenty (20) days, in- and out-of-network combined, per calendar year for inpatient rehabilitation for treatment of alcohol or drug abuse. Counseling: Anthem will pay benefits up to twenty (20) outpatient visits, in- and out-of-network combined, per calendar year for alcohol and drug abuse treatment

	IN-NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY a) Inpatient	30% coinsurance after deductible. Covered for inpatient rehabilitation therapy for up to 30 days per member in each benefit year in- and out-of-network combined.	50% coinsurance after deductible. Covered for inpatient rehabilitation therapy for up to 30 days per member in each benefit year in- and out-of-network combined.
b) Outpatient	30% coinsurance after deductible. Limited to twenty-four (24) visits per calendar year for physical therapy, occupational therapy, and/or chiropractic therapy; in- and out-of-network combined. Speech therapy is limited to twenty (20) visits per member in each calendar year.	50% coinsurance after deductible. Limited to twenty-four (24) visits per calendar year for physical therapy, occupational therapy, and/or chiropractic therapy; in- and out-of-network combined. Speech therapy is limited to twenty (20) visits per member in each calendar year in- and out-of-network combined.
22. OUTPATIENT THERAPY FOR CONGENITAL DEFECTS AND BIRTH ABNORMALITLES	30% coinsurance after deductible Benefits are available up to a member's 6th birthday, limited to 20 visits each for physical therapy, occupational therapy and/or speech therapy per calendar year; in- and out-of-network combined.	50% coinsurance after deductible Benefits are available up to a member's 6th birthday, limited to 20 visits each for physical therapy, occupational therapy and/or speech therapy per calendar year; in- and out-of-network combined.
23. DURABLE MEDICAL EQUIPMENT	30% coinsurance after deductible. For prosthetic devices (arms and legs), benefits are provided with the same deductible and coinsurance as provided by Medicare. Anthem will pay a maximum of $5,000 per calendar year, in- and out-of-network combined. Wigs are covered up to a maximum Anthem payment of $500 per member per calendar year combined in and out-of-network, with a doctor's prescription. Wigs are not subject to the $5,000 maximum Anthem payment for supplies, equipment and appliances. Footwear for diabetes is limited to a $400 maximum Anthem payment per calendar year, in- and out-of-network combined. Footwear is not subject to the $5,000 maximum Anthem payment for supplies, equipment and appliances.	50% coinsurance after deductible. For prosthetic devices (arms and legs), benefits are provided with the same deductible and coinsurance as provided by Medicare. Anthem will pay a maximum of $5,000 per calendar year, in- and out-of-network combined. Wigs are covered up to a maximum Anthem payment of $500 per member per calendar year combined in and out-of-network, with a doctor's prescription. Wigs are not subject to the $5,000 maximum Anthem payment for supplies, equipment and appliances. Footwear for diabetes is limited to a $400 maximum Anthem payment per calendar year, in- and out-of-network combined. Footwear is not subject to the $5,000 maximum Anthem payment for supplies, equipment and appliances.
24. OXYGEN	30% coinsurance after deductible.	50% coinsurance after deductible.
25. ORGAN TRANSPLANTS	30% coinsurance after deductible	50% coinsurance after deductible
26. HOME HEALTH CARE	30% coinsurance after deductible. Limited to sixty (60) visits per member each calendar year, in- and out-of-network combined.	50% coinsurance after deductible. Limited to sixty (60) visits per member each calendar year, in- and out-of-network combined

	IN-NETWORK	OUT-OF-NETWORK
27. HOSPICE CARE **a) Inpatient Care** **b) Outpatient care**	30% coinsurance after deductible. 30% coinsurance Anthem will cover up to $100 per day for routine home care services, in- and out-of-network combined. Please see the Hospice section in your certificate for description of covered services.	50% coinsurance after deductible. 50% coinsurance Anthem will cover up to $100 per day for routine home care services in- and out-of-network combined. Please see the Hospice section in your certificate for a description of covered care services.
28. SKILLED NURSING FACILITY CARE	30% coinsurance after deductible Benefits are limited to one hundred (100) days per member per year, in– and out-of-network combined	50% coinsurance after deductible Benefits are limited to one hundred (100) days per member per year, in– and out-of-network combined
29. DENTAL CARE	Not covered	Not covered
30. VISION CARE	Not covered	Not covered
31. CHIROPRACTIC CARE	Covered under PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY (see line 21)	Covered under PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY (see line 21)
32. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Members who desire another professional opinion may obtain a second surgical opinion. For treatment by a physician or dentist of an Accidental Injury to the natural teeth, if the injury occurs while you are covered under the Agreement, and the services are received within six months of the injury.	

PART C: LIMITATIONS AND EXCLUSIONS

33. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. [10]	12 months for all pre-existing conditions unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions.
34. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No.
35. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health-care professional, or took prescription drugs within 12 months immediately preceding the effective date of coverage.
36. 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

	IN-NETWORK	OUT-OF-NETWORK
37. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield
38. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining preauthorization.	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
39. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
40. What is the main customer service number?	(888) 231-5046	
41.Whom do I write/call if I have a complaint? **Whom do I write if I want to file a grievance?**[11]	Anthem Customer Service Department P.O. Box 17549, Denver, CO 80217-7549 (888) 231-5046 Anthem Quality Management 700 Broadway – MC 0532, Denver, CO 80273	
42. 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 1580 Broadway, Suite 850, Denver, CO 80202	
43. 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 #'06-00341, individual	
44. 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 31.

[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., "$3000 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 deductibles 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 should be noted in boxes 8 through 31.

[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 if complication of pregnancy 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.
[8] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

[9] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

[10] Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

[11] Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Anthem Blue Cross and Blue Shield & HMO Colorado
Health Benefit Plan Description Form Disclosure Amendment

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

Pursuant to Colorado law (C.R.S. §10-16-107(7)(a), services or supplies for the treatment of Intractable Pain and/or Chronic Pain are not covered.

This coverage is renewable at your option, except for the following reasons:

1. **Non-payment of the required premium;**
2. **Fraud or intentional misrepresentation of material fact on the part of the plan sponsor;**
3. **The commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations;**
4. **The carrier elects to discontinue offering and non-renew all of its individual plans delivered or issued for delivery in Colorado.**

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

Payment for an annual Pap test is based on the plan's laboratory services provisions, and payment for the related office visit is based on the plan's preventive care provisions. With our BluePreferred for Individuals PPO Plan, laboratory services for a Pap test are limited to a maximum payment of $75.00. With our Colorado HSA-Compatible Plans for Individuals, all services related to a Pap test are subject to the maximum benefit as described on the Health Benefit Plan Description Form. Under most plans pap tests received out of-network are not covered.

Mammogram Screenings

All plans except our HMO and PPO Basic Health and BluePreferred for Individual Plans provide mammogram screening coverage for women 35 years of age and older. Frequency guidelines can be found in your certificate. Payment for the mammogram screening benefit is based on the plan's provisions for X-ray services. Our HMO and PPO Basic Health Plans do not provide coverage for mammogram screenings.

Prostate Cancer Screenings

All plans except our HMO and PPO Basic Health Plans provide prostate cancer screening coverage for men 40 years of age and older. Frequency guidelines can be found in your certificate. Payment for the prostate cancer screening benefit is based on the plan's provisions for X-ray services. Our HMO and PPO Basic Health Plans do not provide coverage for prostate cancer screenings.

Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All plans provide coverage for colorectal cancer screenings, such as colonoscopies, sigmoidoscopies and fecal occult blood tests. Depending on the type of colorectal cancer screening received, payment for the benefit is based on the plan's provisions for laboratory services, preventive care office visit services, or other medical or surgical services. Our plans do not provide coverage for preventive colorectal cancer screenings involving invasive surgical procedures and DNA analysis. Under most plans colorectal cancer screenings received out of-network are not covered.

The information above is only a summary of the benefits described. The certificate for each health plan includes important additional information about limitations, exclusions and covered benefits. The Health Benefit Plan Description Form for each health plan includes additional information about copayments, deductibles and coinsurance. If you have any questions, please call our customer service department at the phone number on the Health Benefit Plan Description Form.