

## Colorado Health Benefit Plan Description Form Anthem Blue Cross and Blue Shield Hospital Benefits Preferred

### PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED? <sup>1</sup>	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 options reflect the amount the covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. Deductible type <sup>2</sup>	Calendar Year	
4a. ANNUAL DEDUCTIBLE <sup>2a</sup> a) Individual <sup>2b</sup> b) Family <sup>2c</sup>	\$750 \$1,500 aggregate	
	One member may not contribute any more than the individual deductible toward the family deductible.	
5. OUT-OF-POCKET ANNUAL MAXIMUM <sup>3</sup> a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	\$2,500, excludes deductible and copayments \$5,000 aggregate, excludes deductible and copayments No	
	One member may not contribute any more than the individual out-of-pocket annual maximum toward the family out-of-pocket maximum.	
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$6,000,000 per member in- and out-of-network combined for all covered services. Infertility services have an Anthem lifetime maximum benefit of \$2,000 per member in- and out-of-network combined. Bariatric surgery has an Anthem lifetime maximum benefit of \$7,500 per member for services received from a Center of Excellence facility or an Anthem lifetime maximum benefit of \$1,500 per member for services received from a facility that has <b>not</b> been designated as a Center of Excellence; total Anthem lifetime maximum benefit shall not exceed \$7,500 per member in- and out-of-network combined. Major organ transplants have an Anthem lifetime maximum benefit of \$1,000,000 per transplant per member.	\$6,000,000 per member in- and out-of-network combined for all covered services. Infertility services have an Anthem lifetime maximum benefit of \$2,000 per member in- and out-of-network combined. Bariatric surgery has an Anthem lifetime maximum benefit of \$1,500 per member for services received from a facility that has <b>not</b> been designated as a Center of Excellence; total Anthem lifetime maximum benefit shall not exceed \$7,500 per member in- and out-of-network combined.

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Si usted necesita ayuda en español para entender este documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

	IN-NETWORK	OUT-OF-NETWORK
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 benefits.
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 <sup>4</sup> a) Primary Care Providers  b) Specialists	50% coinsurance not subject to deductible  50% coinsurance not subject to deductible  Services performed in a physician office setting are subject to a \$750 Anthem maximum benefit per calendar year. This maximum benefit applies to covered expenses for Routine Medical Office Visits and related services (lab, x-ray, etc.), even when those related services are performed outside the physician's office, or performed or billed by another provider.	
9. PREVENTIVE CARE a) Children's services  b) Adults' services	Up to age 13, 30% coinsurance, not subject to deductible, includes immunizations.  Mammogram and prostate screenings are covered and are not subject to deductible or coinsurance.  30% coinsurance not subject to deductible for all other covered preventive services.  Services performed in a physician office setting are subject to a \$750 Anthem maximum benefit per calendar year. This maximum benefit applies to covered expenses for Routine Medical Office Visits and related services (lab, x-ray, etc.), even when those related services are performed outside the physician's office, or performed or billed by another provider.	Up to age 13, 50% coinsurance, not subject to deductible, includes immunizations.  Not covered except for mammogram and prostate screenings, which are not subject to deductible or coinsurance.  Services performed in a physician office setting are subject to a \$750 Anthem maximum benefit per calendar year. This maximum benefit applies to covered expenses for Routine Medical Office Visits and related services (lab, x-ray, etc.), even when those related services are performed outside the physician's office, or performed or billed by another provider.
10. MATERNITY a) Prenatal care          b) Delivery & inpatient well baby care <sup>5</sup>	\$200 copayment per pregnancy. 30% coinsurance after deductible for all other services (e.g., laboratory and x-ray services) which are part of the office visit.  Prenatal office visit services are not subject to the \$750 preventive care maximum benefit.  30% coinsurance after deductible	50% coinsurance after deductible          Prenatal office visit services are not subject to the \$750 preventive care maximum benefit.  50% coinsurance after deductible.

	IN-NETWORK	OUT-OF-NETWORK
<b>11. PRESCRIPTION DRUGS<sup>6</sup></b> Level of coverage and restrictions on prescriptions <b>a) Outpatient Pharmacy</b>  <b>b) Prescription Mail Service</b>	<p>Generic formulary \$15 copayment or 30% of the negotiated fee for generic self-injectable drugs, per prescription at a participating pharmacy up to a 34-day supply. Prescription Drugs other than generic prescription drugs are not covered.</p> <p>Generic formulary \$30 copayment, per prescription through the mail-order service up to a 90-day supply. Prescription Drugs other than generic prescription drugs are not covered.</p> <p>Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem Blue Cross and Blue Shield, up to \$250 per member per calendar year, \$500 per lifetime.</p> <p>For drugs on our approved list, call customer service at 877-833-5734. Covered only when received from a participating pharmacy.</p>	<p>Not covered</p> <p>Not covered</p>
<b>12. INPATIENT HOSPITAL</b>	30% coinsurance after deductible	50% coinsurance after deductible, up to a maximum of \$650 per day.
<b>13. OUTPATIENT/AMBULATORY SURGERY</b>	30% coinsurance after deductible  Outpatient Surgery related to a physician office visit is subject to limits (see line 8).	Play pays 50% coinsurance after deductible.  Outpatient Surgery related to a physician office visit is subject to limits (see line 8).
<b>14. DIAGNOSTICS</b> <b>a) Laboratory &amp; x-ray</b>  <b>b) MRI, nuclear medicine, and other high-tech services</b>	<p>50% coinsurance after deductible</p> <p>Services related to a physician office visit are not subject to deductible but are subject to limits (see line 8).</p> <p>50% coinsurance after deductible</p> <p>Services related to a physician office visit are subject to limits (see line 8).</p>	<p>50% coinsurance after deductible</p> <p>Services related to a physician office visit are not subject to deductible but are subject to limits (see line 8).</p> <p>50% coinsurance after deductible</p> <p>Services related to a physician office visit are subject to limits (see line 8).</p>
<b>15. EMERGENCY CARE<sup>7, 8</sup></b>	\$100 copayment per visit. 30% coinsurance after copayment and deductible. Copayment is waived if admitted.	
<b>16. AMBULANCE</b> <b>a) Ground</b> <b>b) Air</b>	<p>30% coinsurance after deductible</p> <p>30% coinsurance after deductible</p>	<p>30% coinsurance after deductible</p> <p>30% coinsurance after deductible</p>
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	50% coinsurance after deductible.  Services related to a physician office visit are not subject to deductible but are subject to limits (see line 8).	50% coinsurance after deductible.  Services related to a physician office visit are not subject to deductible but are subject to limits (see line 8).
<b>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE<sup>9</sup></b>	Coverage is no less extensive than the coverage provided for any other physical illness.	

	IN-NETWORK	OUT-OF-NETWORK
19. OTHER MENTAL HEALTH CARE		
a) Inpatient care	50% coinsurance after deductible. Limited to 45 full or 90 partial days per calendar year combined with Alcohol Abuse benefits (see line 20).	Not covered
b) Outpatient care	30% coinsurance after deductible. Limited to 30 visits with no less than \$1,000 in benefits per calendar year.	Not covered
20. ALCOHOL & SUBSTANCE ABUSE		
a) Inpatient Care	<b>Alcohol abuse:</b> 50% after deductible. Limited to 45 days per year or 90 partial days per calendar year combined with mental health benefits (see line 19). <b>Substance abuse:</b> 50% after deductible. Limited to 30 days per calendar year or 60 days per lifetime.	Not covered  Not covered
b) Outpatient care	50% after deductible. Limited to 20 visits with no less than \$500 in Anthem maximum benefit per calendar year for alcohol abuse; limited to 15 visits per calendar year for substance abuse.	Not covered
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY		
a) Children's services	Up to age 5, 30% coinsurance after deductible. Limited to 20 visits each per calendar year for physical, occupational and speech therapy.	Not covered
b) Adults' services	Not covered	Not covered
22. DURABLE MEDICAL EQUIPMENT	Not covered except for prosthetic devices (arms and legs), which are provided with the same deductible and coinsurance as provided by Medicare.	Not covered
23. OXYGEN		
a) Inpatient care	30% coinsurance after deductible.	50% coinsurance after deductible.
b) Outpatient care	Not covered	Not covered
24. ORGAN TRANSPLANTS	30% coinsurance after deductible with benefits limited to \$1,000,000 benefit per transplant. Transportation and lodging costs are limited to an Anthem maximum benefit of \$10,000, donor costs are limited to an Anthem maximum benefit of \$25,000.  Transportation, lodging and donor costs are included in the maximum total lifetime benefit per transplant.	Not covered
25. HOME HEALTH CARE	30% coinsurance after deductible. Limited to 60 visits per calendar year.	Not covered
26. HOSPICE CARE	30% coinsurance after deductible. Limited to three 91-day periods in- and out-of-network combined.	50% coinsurance after deductible. Limited to three 91-day periods in- and out-of-network combined.
27. SKILLED NURSING FACILITY CARE	30% coinsurance after deductible. Limited to 30 days per calendar year in- and out-of-network combined.	50% coinsurance after deductible. Limited to 30 days per calendar year in- and out-of-network combined.

	IN-NETWORK	OUT-OF-NETWORK
28. DENTAL CARE	Dental benefits included in this plan can be found on the Summary of Dental Benefits enclosed.	
29. VISION CARE	Vision benefits included in this plan can be found on the Blue View Vision Summary Description enclosed.	
30. CHIROPRACTIC CARE	Not covered	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Members who desire another professional opinion may obtain a second surgical opinion.	Members who desire another professional opinion may obtain a second surgical opinion.

#### PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. <sup>10</sup>	6 or 18 months for all pre-existing conditions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.
35. 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 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
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
37. 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.
38. 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.
39. What is the main customer service number?	877-833-5734	
40. Whom do I write/call if I have a complaint or want to file a grievance? <sup>11</sup>	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273, 877-833-5734	
41. 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	
42. 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 # 98907_bracketed Small Group	
43. Does the plan have a binding arbitration clause?	Yes	

<sup>1</sup> "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).

<sup>2</sup> "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."

<sup>2a</sup> "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.

<sup>2b</sup> "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.

<sup>2c</sup> "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.

<sup>3</sup> "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.

<sup>4</sup> Medical office visits include physician, mid-level practitioner, and specialist visits.

<sup>5</sup> 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.

<sup>6</sup> Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

<sup>7</sup> "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.

<sup>8</sup> 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.

<sup>9</sup> "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

<sup>10</sup> 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.

<sup>11</sup> Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

## BLUE VIEW VISION SUMMARY OF BENEFITS

### BenefiTs Preferred \$25/\$0 Plan

This Summary of Vision Benefits outlines the vision benefits available to you through the Blue View Vision Plan. This is a summary of your vision benefit. Please review your benefit certificate for plan details. For eligibility definitions please contact your group administrator.

**Anthem's Provider Network:** Blue View Vision contracts with many providers which include independent optometrists and ophthalmologists as well as retail locations. Anthem members have access to approximately 32,000 conveniently located providers nationwide. Members may call Blue View Vision toll-free (866) 723-0515 or visit [www.anthem.com](http://www.anthem.com) any time for provider locations. Schedule an appointment with your Blue View provider; identify yourself as a Blue View Vision member for fast, paperless determination and confirmation of benefits.

**Network Provider:** Maximum benefits are achieved when members access their benefits from a Blue View Vision Participating Provider. Copayment(s) may apply to in-network benefits.

**Non-Network Provider Reimbursements:** Members may go to a non-participating (non-network) provider and pay the provider directly for services and materials. Members may then submit an original itemized invoice and a copy of the prescription along with the Member's I.D. number to **Blue View Vision** for reimbursement according to the Non-Network Reimbursement schedule identified in this *Summary of Vision Benefits*.

**Value Added Savings:** Blue View Vision Providers offer you discount pricing, which is significantly below retail. You receive substantial savings (15% - 40% or more) on additional eyewear pair purchases, contact lenses, lens treatments, specialized lenses and various sundry items.

**Copayment(s):** Copayment amounts are applicable to Network Provider services.

<b>Blue View Vision Benefits</b>	<b>Member Benefit from Network Provider</b>	<b>Non-Network Reimbursement**</b>
<b>Vision Examination:</b> Each member is entitled to a comprehensive vision examination by a Blue View Vision Participating Provider. <b>Availability : Once every 12 months*</b>	<b>\$25.00 Copayment</b>	<b>Up to \$49.00</b>
<b>Lenses:</b> A choice of glass or plastic (CR39) lenses in single vision, and bifocal or trifocal (FT 25-28); lenses up to 55 mm; and all ranges of prescriptions. <b>Single Vision Lenses</b> <b>Bifocal Lenses (pair)</b> <b>Progressive Lenses (pair)</b> <b>Trifocal Lenses (pair)</b> <b>Availability: Once every 24 months*</b>	<b>No Copayment</b> <b>No Copayment</b> <b>Covered up to the bifocal amount for standard progressive lenses. Member pays the difference.</b> <b>No Copayment</b>	<b>Up to \$35.00</b> <b>Up to \$49.00</b> <b>Up to \$49.00</b> <b>Up to \$74.00</b>
<b>Frames</b> <b>Availability: Once every 24 months*</b>	<b>Up to \$120.00</b> Member receives 20% discount on price in excess of \$120.00 maximum.	<b>Up to \$50.00</b>
<b>Contact Lenses***:</b> <b>Elective</b> Conventional  Disposable  <b>Non-elective</b> <b>Availability: Once every 24 months*</b>	Contact Lens allowance applies to fit, follow-up and materials <b>Up to \$115.00</b> Member receives 15% discount on price in excess of \$115.00 maximum.  <b>Up to \$115.00</b>  <b>No Copayment</b>	 <b>Up to \$92.00</b>  <b>Up to \$92.00</b>  <b>Up to \$250.00</b>

\* Benefits are available from the last date of service

\*\* Non-Network Reimbursement represents Plan's allowance toward eligible benefits and may not cover all charges.

\*\*\* See Certificate for definitions of Elective and Non-elective Contact Lenses.

## Limitations and Exclusions:

This is a primary vision care benefit and is intended to cover only eye examinations and corrective eyewear. Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the Plan Design; however, these materials and any items not covered below may be purchased at Preferred Pricing from an Anthem Vision Provider. In addition, benefits are payable only for expenses incurred while the Group and individual Member coverage is in force.

- Orthoptics or vision training and any supplemental testing; Plano (non-prescription) lenses; or two pair of eyeglasses in lieu of bifocals or trifocals.
- Medical or surgical treatment of the eyes.
- An eye exam or corrective eyewear required by an employer as a condition of employment.
- Any injury or illness covered under Workers' Compensation or similar law, or which is work related.
- Sub-normal vision aids.
- Plain or prescription sunglasses or tinted lenses, and no-line bifocals and blended lenses.
- Charges in excess of Usual and Customary for services and materials.
- Experimental or non-conventional treatments or devices.
- Safety eyewear.
- Spectacle lens styles, materials, treatments or "add-ons" not shown in the Summary of Vision Benefits.

## **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.

Pursuant to Colorado law (C.R.S. §10-16-105(5)(g)(I)), small employers purchasing any health benefit plan other than a Basic Health Benefit Plan, must pay for all benefits mandated by Colorado law, including nonwaivable coverages for: newborn, maternity, pregnancy, childbirth, complications from pregnancy and childbirth, therapies for congenital defects and birth abnormalities, low-dose mammography, mental illness, biologically-based mental illness, the availability of alcoholism treatment, the availability of hospice care, prostate cancer screening, child health supervision services, hospitalization and general anesthesia for dental procedures for dependent children, diabetes, and prosthetic devices.

Pursuant to Colorado law (C.R.S. §10-16-105(5)(g)(II)), small employers purchasing a Basic Health Benefit Plan is waiving coverage for low-dose mammography screening, mental illness, prostate cancer screening, hospitalization and general anesthesia for dental procedures for children, the availability of treatment for alcoholism, and the availability of hospice care. All other state-mandated benefits are included in the Basic Health Benefit Plan.

**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 policyholder fails to comply with participation or contribution rules;**
- 4. The carrier elects to discontinue offering and non-renew all of its small group or large group plans delivered or issued for delivery in Colorado;**
- 5. An employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan;**
- 6. With respect to group health benefit plans offered through a managed care plan, there are no longer any enrollees who live, reside or work in the service area; or**
- 7. With respect to coverage of an employer that is made available only through one or more bona fide associations, the membership of an employer ceases.**

**Important Information for Employers with 50 or Fewer Employees and Business Groups of One: Rates are calculated based on allowable case characteristics – age bands, geographic location, family size, health status, and claims experience – and will be given within five working days of request. Rates for a specific employer cannot be adjusted due to the duration of coverage of employees or dependents of the small employer. Rates may change based on case characteristics, whenever benefits are changed, or upon giving written notice to the employer not less than 31 days prior to the effective date of the change. New applicants may be subject to pre-existing condition clauses, based on HIPAA requirements. Renewal of health insurance coverage in this class is guaranteed, assuming compliance with underwriting regulations. A Network Access Plan, which describes Anthem Blue Cross and Blue Shield's or HMO Colorado's network standards and evaluation procedures for ensuring provider access is available by calling our customer service department.**

**COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS SPECIFIED BY LAW.**

## **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 except our BeneFits plans provide coverage for an annual Pap test and the related office visit. Payment for the Pap test is based on the plan's provisions for laboratory or preventive care services, and payment for the related office visit is based on the plan's preventive care provisions. Under most plans pap tests received out-of-network are not covered.

### **Mammogram Screenings**

All plans except our HMO and PPO Basic Health Plans provide mammogram screening coverage for women. Frequency guidelines can be found in your certificate. Payment for the mammogram screening benefit is based on the plan's provisions for preventive care 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. Frequency guidelines can be found in your certificate. Payment for the prostate cancer screening benefit is based on the plan's provisions for preventive care 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 except our BeneFits 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 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.