

Colorado Health Benefit Plan Description Form

Anthem Blue Cross and Blue Shield

Name of Carrier

PPO \$25/50 Copay \$1,500 Deductible

Name of Plan

PART A: TYPE OF COVERAGE

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| 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 options reflect the amount the covered person will pay.

| | IN-NETWORK | OUT-OF-NETWORK |
|-------------------------------------|--|--|
| 4. Deductible Type ² | Calendar Year | Calendar Year |
| 4a. ANNUAL DEDUCTIBLE ^{2a} | | |
| a) Individual ^{2b} | \$1,500, excludes copayments | \$3,000 |
| b) Family ^{2c} | \$3,000 aggregate, excludes copayments | \$6,000 aggregate |
| | Some covered services have a maximum benefit of days, visits or dollar amounts allowed during a calendar year. When the deductible is applied to a covered service which has a maximum number 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. | Some covered services have a maximum benefit of days, visits or dollar amounts allowed during a calendar year. When the deductible is applied to a covered service which has a maximum number 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. |

| | IN-NETWORK | OUT-OF-NETWORK |
|--|---|--|
| <p>5. OUT-OF-POCKET ANNUAL MAXIMUM³</p> <p>a) Individual</p> <p>b) Family</p> <p>c) Is deductible included in the out-of-pocket maximum?</p> | <p>\$2,500 excludes deductible and copayments</p> <p>\$5,000 aggregate, excludes deductible and copayments</p> <p>One member may not contribute any more than the individual out-of-pocket annual maximum toward the family out-of-pocket annual maximum.</p> <p>No</p> <p>Some covered services have a maximum number of days, visits or dollar amounts allowed during a calendar year. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied.</p> | <p>\$5,000 excludes deductible</p> <p>\$10,000 aggregate, excludes deductible</p> <p>One member may not contribute any more than the individual out-of-pocket annual maximum toward the family out-of-pocket annual maximum.</p> <p>No</p> <p>Some covered services have a maximum number of days, visits or dollar amounts allowed during a calendar year. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied. The difference between billed charges and the maximum allowed amount for non-participating providers does not count toward the out-of-pocket annual maximum. Even once the out-of-pocket annual maximum is satisfied, the member will still be responsible for paying the difference between the maximum allowed amount and the non-participating providers billed charges.</p> |
| <p>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</p> | <p>\$6,000,000 per member in- and out-of-network combined for all covered services. Infertility diagnostic services have a lifetime maximum benefit of \$2,000 per member in- and out-of-network combined.</p> | <p>\$6,000,000 per member in- and out-of-network combined for all covered services. Infertility diagnostic services have a lifetime maximum benefit of \$2,000 per member in- and out-of-network combined.</p> |
| <p>7A. COVERED PROVIDERS</p> | <p>Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list of current providers.</p> | <p>All providers licensed or certified to provide covered benefits.</p> |
| <p>7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?</p> | <p>Yes</p> | <p>Yes</p> |

| | IN-NETWORK | OUT-OF-NETWORK |
|---|--|---|
| <p>11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions⁶</p> <p>a) Inpatient care</p> <p>b) Outpatient Pharmacy</p> <p>c) Prescription Mail Service</p> | <p>Included with the inpatient hospital benefit (see line 12)</p> <p>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.</p> <p>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 mail-order pharmacy.</p> <p>Mail-Order Pharmacy Drugs - Tier 1 \$15 copayment, tier 2 \$80 copayment, tier 3 \$120 copayment, tier 4 30% copayment, per prescription through the mail-order service up to a 90-day supply. For the tier 4 mail-order 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 mail-order service.</p> <p>The following applies to b) and c) above: Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem, up a \$500 per lifetime maximum benefit.</p> <p>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 expenses. You may request, or your provider may order, the brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and brand-name drug, in addition to your tier 1 copayment. By law, generic and brand-name drugs must meet the same standards for safety, strength, and effectiveness. Anthem reserves the right, at our discretion, to remove certain higher cost generic drugs from this policy. For drugs on our approved list, call customer service at 877-833-5734.</p> | <p>Included with inpatient hospital benefit (see line 12)</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p> |

| | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| 12. INPATIENT HOSPITAL | 20% coinsurance after deductible | 50% coinsurance after deductible |
| 13. OUTPATIENT/AMBULATORY SURGERY | 20% coinsurance after deductible | 50% coinsurance after deductible |
| 14. DIAGNOSTICS | | |
| a) Laboratory & x-ray | 20% coinsurance after deductible for laboratory or x-ray services which are not included in the applicable visit copayment or that were billed on a different date than the office visit. | 50% coinsurance after deductible |
| b) MRI, nuclear medicine, and other high-tech services | 20% coinsurance after deductible | 50% coinsurance after deductible |
| 15. EMERGENCY CARE ^{7,8} | 20% coinsurance after deductible | Out-of-network care is paid as in-network |
| 16. AMBULANCE | | |
| a) Ground | 20% coinsurance after deductible | Out-of-network care is paid as in-network |
| b) Air | 20% coinsurance after deductible | Out-of-network care is paid as in-network |
| 17. URGENT, NON-ROUTINE, AFTER HOURS CARE | \$50 copayment per visit; no coinsurance (100% covered) for all other services which are performed in the physician's office and billed by the physician (e.g., laboratory and x-ray services). Services performed or billed by another provider are not included in the visit copayment, see line 14 for payment information. Excludes MRI, CT, PET scans, nuclear medicine and other high-tech services, see line 14. | 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. OTHER MENTAL HEALTH CARE | | |
| a) Inpatient care | 20% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law. | 50% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law. |
| b) Outpatient care | Up to \$25 copayment for PCP or \$50 copayment for specialist per office visit, subject to any applicable cost-share maximums imposed by law. | 50% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law. |
| 20. ALCOHOL & SUBSTANCE ABUSE | | |
| a) Inpatient Care | 20% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law. | 50% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law |
| b) Outpatient care | Up to \$25 copayment for PCP or \$50 copayment for specialist per office visit, subject to any applicable cost-share maximums imposed by law. | 50% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law. |

| | IN-NETWORK | OUT-OF-NETWORK |
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| <p>21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY</p> <p>a) Inpatient</p> <p>b) Outpatient</p> | <p>20% coinsurance after deductible. Covered for inpatient rehabilitation therapy for up to 30 non-acute inpatient days per calendar year in- and out-of-network combined.</p> <p>20% coinsurance after deductible. Limited to 20 visits each for physical, occupational or speech therapy per calendar year in and out-of-network combined. From birth until the member's sixth birthday, benefits are provided as required by applicable law.</p> | <p>50% coinsurance after deductible. Covered for inpatient rehabilitation therapy for up to 30 non-acute inpatient days per calendar year in- and out-of-network combined.</p> <p>50% coinsurance after deductible. Limited to 20 visits each for physical, occupational or speech therapy per calendar year in and out-of-network combined. From birth until the member's sixth birthday, benefits are provided as required by applicable law.</p> |
| 22. DURABLE MEDICAL EQUIPMENT | 20% coinsurance after deductible with benefits limited to a maximum benefit of \$3,000 per calendar year. The \$3,000 maximum benefit is combined to include Durable Medical Equipment (line 22) and Oxygen (line 23). For prosthetic devices (arms and legs), benefits are provided with the same deductible and coinsurance as provided by Medicare. Prosthetic devices for arms and legs are not subject to, or limited by, the maximum benefit of \$3,000. | Not covered |
| 23. OXYGEN | 20% coinsurance after deductible with benefits limited to a maximum benefit of \$3,000 per calendar year, combined with durable medical equipment (see line 22). | Not covered |
| <p>24. ORGAN TRANSPLANTS</p> <p>a) Inpatient</p> <p>b) Outpatient</p> | <p>20% coinsurance after deductible</p> <p>\$25 copayment for PCP or \$50 copayment for specialist per office visit; no coinsurance (100% covered) for all other services which are performed in the physician's office and billed by the physician (e.g., laboratory and x-ray services). Services performed or billed by another provider are not included in the visit copayment, see line 14 for payment information. Excludes MRI, CT, PET scans, nuclear medicine and other high-tech services, see line 14.</p> <p>Transportation and lodging services are limited to a maximum benefit of \$10,000; unrelated donor searches are limited to a maximum benefit of \$30,000.</p> | <p>Not covered</p> <p>Not covered</p> |
| 25. HOME HEALTH CARE | 20% coinsurance after deductible. Limited to 100 visits per calendar year. | Not covered |
| 26. HOSPICE CARE | 20% coinsurance after deductible | 50% coinsurance after deductible |
| 27. SKILLED NURSING FACILITY CARE | 20% coinsurance after deductible. Limited to 100 days per calendar year in- and out-of-network combined. | 50% coinsurance after deductible. Limited to 100 days per calendar year in- and out-of-network combined. |
| 28. DENTAL CARE | Not covered | Not covered |
| 29. VISION CARE | Not covered | Not covered |

| | IN-NETWORK | OUT-OF-NETWORK |
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| 30. CHIROPRACTIC CARE | \$20 copayment per visit, no coinsurance (100% covered) for all other services which are performed in the chiropractor's office and billed by the chiropractor (e.g., laboratory and x-ray services). Services performed or billed by another provider are not included in the visit copayment, see line 14 for payment information. Limited to 20 visits per calendar year combined with massage therapy and acupuncture care. | Not covered |
| 31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) | <p>Alternative Services Massage Therapy/Acupuncture Care \$20 copayment per visit, no coinsurance (100% covered) for all other services which are performed in the massage therapists or acupuncturist's office and billed by the massage therapists or acupuncturist (e.g., laboratory and x-ray services). Services performed or billed by another provider are not included in the visit copayment; see line 14 for payment information. Limited to 20 visits per calendar year combined with chiropractic care.</p> <p>Nutritional Therapy \$20 copayment per visit for specialist. Limited to 4 visits per calendar year.</p> <p>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.</p> <p>Treatment of Autism Spectrum Disorders Benefit level determined by type of service provided.</p> <p>The following annual maximums, based on calendar year, are effective for applied analysis services for in- and out-of-network services combined:</p> <ul style="list-style-type: none"> • From birth to age eight (up to member's ninth birthday): \$34,000 in and out-of-network combined • Age nine to age eighteen (up to member's nineteenth birthday): \$12,000 in and out-of-network combined | <p>Not covered</p> <p>Not covered</p> <p>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.</p> <p>Treatment of Autism Spectrum Disorders Benefit level determined by type of service provided.</p> <p>The following annual maximums, based on calendar year, are effective for applied analysis services for in- and out-of-network services combined:</p> <ul style="list-style-type: none"> • From birth to age eight (up to member's ninth birthday): \$34,000 in and out-of-network combined • Age nine to age eighteen (up to member's nineteenth birthday): \$12,000 in and out-of-network combined |

PART C: LIMITATIONS AND EXCLUSIONS

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| 32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. ¹⁰ | 6 months for all pre-existing conditions. |
| 33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy? | No |

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| 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 |
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| 36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases? | No | No |
| 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 | 877-833-5734 |
| 40. Whom do I write/call if I have a complaint or want to file a grievance? ¹¹ | Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway Denver, CO 80273 877-833-5734 | 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 | 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 #'s 2986_Copay Group – Small Group Only | Policy form #'s 2986_Copay Group – Small Group Only |
| 43. Does the plan have a binding arbitration clause? | Yes | 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.

For those enrolled on a health benefit plan other than the Colorado Basic Limited Mandate Health Benefit Plan:

Small employers purchasing any health benefit plan other than the Colorado Basic Limited Mandate Health Benefit Plan must pay for all of the mandated benefits pursuant to section 10-16-104, C.R.S. The premium for this plan includes the cost of these mandated benefits, specifically: 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, hospitalization and general anesthesia for dental procedures for dependent children, diabetes, prosthetic devices, early intervention services for certain children, colorectal screening, cervical cancer vaccinations, and certain routine care during participation in a clinical trial. Pursuant to Colorado law (C.R.S. §10-16-105(5)(g)(l)), 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.

For those enrolled on the Colorado Basic Limited Mandate Health Benefit Plan:

Interested policyholders, certificate holders, and enrollees are hereby given notice that this small group policy does not cover all the health services and benefits, including prostate screenings, mental health, alcoholism, and dental anesthesia for children, which the Colorado Revised Statutes usually require group plans to cover.

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, tobacco usage, and industry factor – 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 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 service. 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 one routine screening or diagnostic mammogram per year regardless of age (or in accordance with the frequency determined by your provider) for women. Payment for the mammogram screening benefit is based on the plan's provisions for preventive care and is normally not subject to the deductible or coinsurance.

Prostate Cancer Screenings

All plans except our HMO and PPO Basic Health Plans provide coverage under the preventive care benefits for one routine prostate cancer screening per year regardless of age (or in accordance with the frequency determined by your provider) for men. Payment for the prostate cancer screening is based on the plan's provisions for preventive exam and laboratory services and is normally not subject to the deductible or coinsurance.

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, sigmoidscopies 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 are not subject to the deductible or coinsurance.

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.