

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? 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	
4a. ANNUAL DEDUCTIBLE ^{2a} a) Individual ^{2b} b) Family ^{2c}	\$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 ³ 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. Some covered services have a maximum numbers 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.	
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 diagnostic 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 not 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.	\$6,000,000 per member in- and out-of-network combined for all covered services. Infertility diagnostic 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 not 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 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.

	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 ⁴ 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. Preventive colorectal cancer screening is covered and is not subject to deductible, but is subject to 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 and preventive colorectal cancer screening which is not subject to deductible, but is subject to 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 ⁵	\$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, up to a maximum of \$650 per day.

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS⁶ Level of coverage and restrictions on prescriptions a) Outpatient Pharmacy b) Prescription Mail Service	<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 30-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 a \$500 per lifetime maximum benefit.</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>
12. INPATIENT HOSPITAL	30% coinsurance after deductible	50% coinsurance after deductible, up to a maximum of \$650 per day.
13. OUTPATIENT/AMBULATORY SURGERY	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).
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, and other high-tech services	<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>
15. EMERGENCY CARE^{7, 8}	\$100 copayment per visit. 30% coinsurance after copayment and deductible. Copayment is waived if admitted.	
16. AMBULANCE a) Ground b) Air	<p>30% coinsurance after deductible</p> <p>30% coinsurance after deductible</p>	<p>30% coinsurance after deductible</p> <p>30% coinsurance after deductible</p>
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	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).
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹	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 b) Outpatient care	<p>30% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law.</p> <p>30% coinsurance (not subject to deductible), subject to a maximum benefit of \$1,000 per calendar year for office visits; 30% coinsurance after deductible for facility.</p> <p>Subject to any applicable cost-share maximums imposed by law.</p> <p>The maximum benefit of \$1,000 for office visits is combined with out-of-network services.</p>	<p>50% coinsurance after deductible, up to a maximum of \$650 per day, subject to any applicable cost-share maximums imposed by law.</p> <p>50% coinsurance (not subject to deductible), subject to a maximum benefit of \$1,000 per calendar year for office visits; 50% coinsurance after deductible for facility.</p> <p>Subject to any applicable cost-share maximums imposed by law.</p> <p>The maximum benefit of \$1,000 for office visits is combined with in-network services.</p>
20. ALCOHOL & SUBSTANCE ABUSE a) Inpatient Care b) Outpatient care	<p>30% coinsurance after deductible, subject to any applicable cost-share maximums imposed by law.</p> <p>50% coinsurance (not subject to deductible), subject to a maximum benefit of \$750 per calendar year for office visits; 30% coinsurance after deductible for facility.</p> <p>Subject to any applicable cost-share maximums imposed by law.</p> <p>The maximum benefit of \$750 for office visits is combined with out-of-network services.</p>	<p>50% coinsurance after deductible, up to a maximum of \$650 per day, subject to any applicable cost-share maximums imposed by law.</p> <p>50% coinsurance (not subject to deductible), subject to a maximum benefit of \$750 per calendar year for office visits; 50% coinsurance after deductible for facility.</p> <p>Subject to any applicable cost-share maximums imposed by law.</p> <p>The maximum benefit of \$750 for office visits is combined with in-network services.</p>
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY a) Children's services b) Adults' services	<p>Up to age 5, 30% coinsurance after deductible. Limited to 20 visits each per calendar year for physical, occupational and speech therapy, from birth until the third birthday benefits are provided as required by applicable law.</p> <p>Not covered</p>	<p>Not covered</p> <p>Not covered</p>
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 and hearing aids for children up to age 18.	Not covered
23. OXYGEN a) Inpatient care b) Outpatient care	<p>30% coinsurance after deductible.</p> <p>Not covered</p>	<p>50% coinsurance after deductible, up to a maximum of \$650 per day.</p> <p>Not covered</p>
24. ORGAN TRANSPLANTS	30% coinsurance after deductible. Transportation and lodging services are limited to a maximum benefit of \$10,000; unrelated donor searches are limited to a	Not covered

	IN-NETWORK	OUT-OF-NETWORK
	maximum benefit of \$30,000.	
25. HOME HEALTH CARE	30% coinsurance after deductible. Limited to 100 visits per calendar year.	Not covered
26. HOSPICE CARE	30% coinsurance after deductible	50% coinsurance after deductible
27. SKILLED NURSING FACILITY CARE	30% coinsurance after deductible. Limited to 100 days per calendar year in- and out-of-network combined.	50% coinsurance after deductible, up to a maximum of \$650 per day. Limited to 100 days per calendar year in- and out-of-network combined.
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)	<p>Nutritional Therapy 50% coinsurance not subject to deductible. Services are subject to the limits of a physician office visit (see line 8) up 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>Members who desire another professional opinion may obtain a second surgical opinion.</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>Members who desire another professional opinion may obtain a second surgical opinion.</p>

PART C: LIMITATIONS AND EXCLUSIONS

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
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.

	IN-NETWORK	OUT-OF-NETWORK
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? ¹¹	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 # 2989_BeneFits_PREFERRED Small Group	
43. 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.

BeneFits PPO Dental Plan

Summary of Benefits



This is not a contract. All covered services are subject to the conditions, exclusions, qualifications, limitations, terms and provisions of the Anthem Blue Cross and Blue Shield BeneFits PPO Dental Certificate. For a covered dental service, this coverage will pay the applicable percentage or specified dollar amount (shown in the "Plan Pays (Maximum Allowable Amount)" column) of the Anthem Blue Cross and Blue Shield Dental maximum allowable for that service (up to the Annual Maximum). Please contact customer service to verify your dental coverage.

BENEFITS WILL BE PROVIDED ONLY FOR THE COVERED SERVICES SPECIFIED IN THIS SUMMARY OF BENEFITS. NO BENEFITS WILL BE PROVIDED FOR ANY OTHER SERVICES.

Annual Member Deductible	\$25 combined for network and non-network providers
Family Coverage Deductible Limit	3 times Annual Member Deductible

Covered Services		Plan Pays (Maximum Allowable Amount)	
		Network Providers	Non-Network Providers
Annual Maximum		\$500 combined for network and non-network providers	
Diagnostic and Preventive Services (deductible waived for in Network)			
Procedure	Description		
*D0120	Periodic Oral Exam	100%	\$18
*D0140	Limited Oral Evaluation-Problem Focused	100%	\$28
*D0150	Comprehensive/Initial Oral Exam	100%	\$25
*D0160	Detailed and extensive oral evaluation - new or established patient	100%	\$49
*D0170	Re-evaluation - limited, problem focused	100%	\$28
*D0180	Comprehensive Periodontal Evaluation-new or established patient	100%	\$28
**D0210	Intraoral--Complete Series Including Bitewings	100%	\$60
D0220	Intraoral--Periapical--First Film	100%	\$13
D0230	Intraoral--Periapical--Each Additional Film	100%	\$8
D0240	Intraoral - Occusal film	100%	\$17
D0250	Extraoral - First film	100%	\$16
D0260	Extraoral - Each Additional Film	100%	\$10
D0270	Bitewing -- one Film	100%	\$16
D0272	Bitewings--two Films	100%	\$18
D0274	Bitewings--four Films	100%	\$26
D0277	Vertical Bitewings	100%	\$16
**D0290	Posterior-Anterior or Lateral skull and Facial Bone Survey Film	100%	\$50
**D0330	Panoramic Film	100%	\$36
**D0340	Cephalometric film	100%	\$38
D1110	Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	100%	\$39
D1120	Prophylaxis (teeth cleaning child-through age 18) (limited to 2 per Year)	100%	\$30
D1201	Prophylaxis (teeth cleaning child-through age 18) with fluoride (limited to 2 per Year)	100%	\$35
D1203	Topical fluoride only (child through age 18) (limited to 2 per Year)	100%	\$14
D1204	Topical Appl. of Fluoride Excl. Prophy--Adult	Not covered	Not covered
D1205	Topical fluoride with Prophylaxis (teeth cleaning adult) (limited to 2 per Year)	100%	\$39

Covered Services		Plan Pays (Maximum Allowable Amount)	
		Network Providers	Non-Network Providers
Fillings (deductible applies)			
Procedure	Description		
D2140	Amalgam--One Surface Permanent or Primary	80%	\$42
D2150	Amalgam--Two Surfaces Permanent or Primary	80%	\$55
D2160	Amalgam--Three Surfaces Permanent or Primary	80%	\$72
D2161	Amalgam -- 4 or more surface, Permanent or Primary	80%	\$84
D2330	Resin--One Surface, Anterior	80%	\$42
D2331	Resin--Two Surfaces, Anterior	80%	\$55
D2332	Resin--Three Surfaces, Anterior	80%	\$72
D2335	Resin 4-surface incisal	80%	\$84
D2390	Resin-based composite crown, anterior	80%	\$85
***D2391	Resin-based composite-one surface posterior	80%	\$42
D2392	Resin-based composite-two surfaces posterior	80%	\$55
D2393	Resin-based composite-three surfaces posterior	80%	\$72
D2394	Resin-based composite-four surfaces posterior	80%	\$84
All Other Services		Not covered	Not covered

* Exams are limited to two per Year.

** Full mouth X-rays or its equivalent are limited to one set every three (3) Years.

*** If a tooth or teeth can be restored with amalgam (with the exception of composite resin on anterior teeth) any amount exceeding the cost of that material is not covered if another material is used. Anterior teeth exhibiting pathology eligible for composite restorations are central incisors, lateral incisors, cuspids and the facial surface of bicuspid.

Anthem Blue Cross and Blue Shield Dental Customer Service: (888) 209-7852

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 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.

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

* 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, and the availability of treatment for alcoholism. 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 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 laboratory services or preventive care service. 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 since under most plans coverage for preventive care is not covered out-of-network.

Mammogram Screenings

All plans except our HMO and PPO Basic Health 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, sigmoidoscopies and colonoscopies. Depending on the type of colorectal cancer screening received, payment for the benefit is based on where the services are rendered and if rendered as a screening or medical procedure. Colorectal cancer screenings are covered under preventive care as long as the services provided are for a preventive screening. Our plans do not provide coverage for preventive colorectal cancer screenings involving DNA analysis.

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.