

**Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield**

Name of Carrier

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

Name of Plan

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 Type²	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE^{2a}		
a) Individual^{2b}	\$1,500, excludes copayments	\$3,000
b) Family^{2c}	\$4,500, excludes copayments	\$9,000
	One member may not contribute any more than the individual Deductible towards the family Deductible.	One member may not contribute any more than the individual Deductible towards the family Deductible.
	Some covered services have a maximum benefit of days, visits or dollar amounts. 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. 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.

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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
5. OUT-OF-POCKET ANNUAL MAXIMUM³ a) Individual b) Family c) Is deductible included in the out-of-pocket maximum?	\$2,500 excludes deductible and copayments \$5,000, excludes deductible and copayments One member may not contribute any more than the individual out-of-pocket annual maximum toward the family out-of-pocket annual maximum. No Some covered services have a maximum number of days, visits or dollar amounts. These maximums apply even if the applicable out-of-pocket annual maximum is satisfied.	\$5,000 excludes deductible \$10,000, excludes deductible One member may not contribute any more than the individual out-of-pocket annual maximum toward the family out-of-pocket annual maximum. No Some covered services have a maximum number of days, visits or dollar amounts. 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.
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime maximum for most covered services. Infertility diagnostic services have a lifetime maximum benefit of \$2,000 per member in- and out-of-network combined.	No lifetime maximum for most covered services. Infertility diagnostic services have a lifetime maximum benefit of \$2,000 per member in- and out-of-network combined.
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

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions⁶		
a) Inpatient care	Included with the inpatient hospital benefit (see line 12)	Included with inpatient hospital benefit (see line 12)
b) Outpatient Pharmacy	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. 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.	Not covered Not covered
c) Prescription Mail Service	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.	Not covered
	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. Tier 4 prescription drug copayments will accrue to a maximum copayment of \$3,500 per member per calendar year. Once the member has satisfied the \$3,500 maximum copayment, no additional copayments will be required for the remainder of the calendar year for tier 4 prescription drugs.	Not covered
	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.	

	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	No copayment, coinsurance or deductible (100% covered) for laboratory services performed by the physician, freestanding laboratory provider or outpatient facility. \$50 copayment per date of service for x-ray services.	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, 100% covered for non-laboratory and x-ray services, which are performed in the provider and billed by the provider. For laboratory and x-ray services, see line 14 for payment information.	50% coinsurance after deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹	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	Mental health care includes without limitation, biologically based mental illness, care that has a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition.	Mental health care includes without limitation, biologically based mental illness, care that has a psychiatric diagnosis or that require specific psychotherapeutic treatment, regardless of the underlying condition.
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
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY a) Inpatient b) Outpatient	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. 20% coinsurance after deductible. Up 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.	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. 50% coinsurance after deductible. Up 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.
22. DURABLE MEDICAL EQUIPMENT	20% coinsurance after deductible	Not covered
23. OXYGEN	20% coinsurance after deductible	Not covered
24. ORGAN TRANSPLANTS a) Inpatient b) Outpatient	20% coinsurance after deductible \$25 copayment for PCP or \$50 copayment for specialist per office visit, 100% covered for non-laboratory and x-ray services, which are performed in the physician's office and billed by the physician. For laboratory and x-ray services, see line 14 for payment information. 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.	Not covered Not covered
25. HOME HEALTH CARE	20% coinsurance after deductible. Up to 100 visits per calendar year.	Not covered
26. HOSPICE CARE	Covered person pays no deductible or coinsurance (100% covered)	50% coinsurance after deductible
27. SKILLED NURSING FACILITY CARE	20% coinsurance after deductible. Up to 100 days per calendar year in- and out-of-network combined.	50% coinsurance after deductible. Up 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
30. CHIROPRACTIC CARE	\$20 copayment per office visit, 100% covered for non-laboratory and x-ray services, which are performed in the provider's office and billed by the provider. For laboratory and x-ray services, see line 14 for payment information. Up 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>Retail Health Clinic \$25 copayment per office visit, 100% covered for non-laboratory and x-ray services, which are performed in the physician's office and billed by the physician. For laboratory and x-ray services, see line 14 for payment information.</p> <p>Other Covered Services</p> <ul style="list-style-type: none"> • Massage Therapy/Acupuncture Care - \$20 copayment per visit, 100% covered for non-laboratory and x-ray services, which are performed in the provider's office and billed by the provider. For laboratory and x-ray services, see line 14 for payment information. Up to 20 visits per calendar year combined with chiropractic care. • Nutritional Therapy - \$20 copayment per visit for specialist. Up to 4 visits per calendar year. <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 behavior 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>General Information For any outpatient covered service not elsewhere listed, covered person pays coinsurance after deductible. For example, this includes chemotherapy and outpatient non-surgical facility services.</p>	<p>Retail Health Clinic 50% coinsurance after deductible</p> <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 behavior 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>General Information For any outpatient covered service not elsewhere listed, covered person pays coinsurance after deductible. For example, this includes chemotherapy and outpatient non-surgical facility services.</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	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 COSGPPO Group – Small Group	Policy form #'s COSGPPO Group – Small Group
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.

All services are subject to medical necessity. Medical necessity means an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that Anthem or HMO Colorado, subject to a member's right to appeal, solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a physician and/or licensed, certified or registered provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost).
- Not experimental/investigational.
- Not primarily for the convenience of the member, the member's family or the provider.
- Not otherwise subject to an exclusion under the Certificate.

The fact that a physician and/or provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies medically necessary.

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). 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. 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.

SUMMARY OF THE LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Introduction

Residents of Colorado who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Life and Health Insurance Protection Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Colorado and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

IMPORTANT DISCLAIMER

The Life and Health Insurance Protection Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require residency in Colorado. You should not rely on coverage by the Life and Health Insurance Protection Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the association to induce you to purchase any kind of insurance policy.

Summary

The state law that provides for this safety-net coverage is called the Life and Health Insurance Protection Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association.

Coverage. Generally, individuals will be protected by the Life and Health Insurance Protection Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Certain parties to structured settlement annuity contracts may be entitled to coverage benefits as well based on defined circumstances.

This Information is Provided By:

Life & Health Insurance
Protection Association
P.O. Box 36009
Denver, CO 80236
(303) 292-5022

Colorado Division of Insurance
1560 Broadway
Suite 850
Denver, CO 80202
(303) 894-7499

Exclusions From Coverage. Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Colorado, except under certain very specific circumstances
- the insurer was not authorized or licensed to do business in Colorado at the time the policy or contract was issued;
- their policy was issued by a nonprofit hospital or health service corporation, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rate yields, crediting rate yields or other factors employed in calculating returns, including but not limited to indexes or other external references stated in the policy or contract, that exceed an average rate specified in the Association Act;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- any unallocated annuity;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- policies or contracts issued by an insurer which was insolvent or unable to fulfill its contractual obligations as of July 1, 1991, except for annuity contracts issued by a member insurer which was placed into liquidation between July 1, 1991, and August 31, 1991;
- policies or contracts covering persons who are not citizens of the United States;
- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

Limits On Amount Of Coverage. The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the Association will pay a maximum of:

- \$300,000 in net life insurance death benefits and no more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits - \$100,000 for coverages not defined as disability, basic hospital, medical and surgical, or major medical insurance, including any net cash surrender and net cash withdrawal values; \$300,000 for disability insurance; or \$500,000 for basic hospital, medical and surgical, or major medical insurance;
- \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or
- with respect to each payee of a structured settlement annuity, \$250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- \$300,000 for long term care benefits.

The Association shall not be liable to expend more than \$300,000 in the aggregate, with respect to any one life except that with respect to benefits for basic hospital, medical and surgical and major medical insurance, the aggregate liability of the Association shall not exceed \$500,000 with respect to any one individual.