Anthem
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Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
Colorado Individual SmartSense Plus Child-Only 2500 Standard Rx
Effective August 1, 2011

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED?[1]	Yes, but the patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. DEDUCTIBLE TYPE[2]	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE[2a] a) Single[2b] b) Non-single[2c]	$ 2,500 Family coverage not provided	$ 2,500 Family coverage not provided
	Prescription drug expenses do not apply towards this deductible. Copayment amounts do not apply to the deductible.	
5. OUT-OF-POCKET ANNUAL MAXIMUM a) Individual[3] b) Family c) Is the deductible included in the out-of-pocket maximum?	$ 7,500 Includes deductible and coinsurance. Family coverage not provided Yes	$ 11,500 Includes deductible and coinsurance. Family coverage not provided Yes
	Prescription drug expenses do not apply towards this Out of Pocket maximum. Copayment amounts do not apply to the out of pocket maximum.	
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime limits. For benefit limits please see each applicable benefit below.	
7a. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list or current providers.	All providers licensed or certified to provide covered benefits.

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	IN-NETWORK	OUT-OF-NETWORK
7b. With respect to network plans, are all the providers listed in 7a accessible to me through my primary care physician?	Yes	Yes
8. MEDICAL OFFICE VISITS[4] a) Primary Care Providers b) Specialists	$30 copayment per office visit when included in the first three (3) office visits in a calendar year; then 30% coinsurance after deductible. $30 copayment per office visit when included in the first three (3) office visits in a calendar year; then 30% coinsurance after deductible. Not all covered services provided through the physician's office will be included in, or paid at the same level as, an office visit. Copayment amounts do not apply to the deductible or the out of pocket maximum.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount. 50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
9. PREVENTIVE CARE a) Children's services	Preventive Care Services shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the covered member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below: 1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: • Breast cancer; • Cervical cancer; • Colorectal cancer; • High Blood Pressure; • Type 2 Diabetes Mellitus; • Cholesterol; • Child and Adult Obesity. 2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and 4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.	$30 copay per office visit. Deductible waived. No coinsurance required for: Early intervention services, preventive services and immunizations (including the cervical cancer vaccination) pursuant to the schedule established by the Advisory Committee on Immunization Practices. Child health supervision services shall be provided up to age 13. Child health supervision services shall be exempt from a deductible or dollar limit provision. Copayments and coinsurance may be imposed for child health supervision services, but they shall not exceed the copayment or coinsurance payment, as applicable, to a physician visit. 50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount for any other covered preventive care services not mandated by Colorado law.
	Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.	

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE (continued) b) Adults' services	Preventive Care Services shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the covered member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below: 1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: • Breast cancer; • Cervical cancer; • Colorectal cancer; • High Blood Pressure; • Type 2 Diabetes Mellitus; • Cholesterol; • Child and Adult Obesity. 2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and 4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.	$30 copayment per office visit Deductible waived. No coinsurance required for: Routine cytological screening (pap test), mammography benefit in accordance with Colorado law, colorectal cancer examination and related laboratory tests, cholesterol screening, immunizations against cervical cancer, influenza and pneumococcal vaccinations, alcohol misuse and tobacco use screening and behavioral counseling or cessation interventions, and prostate cancer screening. 50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount for any other covered preventive care services not mandated by Colorado law. Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.
	Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.	
10. MATERNITY a) Prenatal care	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) Delivery & inpatient well baby care[5]	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions a) Outpatient care	Participating Retail Pharmacy: Tier 1 Prescription Drugs: o $15 copayment for each prescription and/or refill for a maximum thirty (30) day supply. Tier 2 Prescription Drugs: After the $7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied: o $40 copayment for each prescription and/or refill for a maximum thirty (30) day supply. Tier 3 Prescription Drugs: After the $7,500 Tier2 and Tier 3 Prescription Drug Deductible has been satisfied: o 50% coinsurance for each prescription and/or refill for a maximum thirty (30) day supply. Tier 3 Specialty Prescription Drugs*: After the $7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied: o 50% coinsurance, for each prescription and/or refill for a maximum thirty (30) day supply. *Specialty Pharmacy Drugs: Specialty drugs are high-cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty drugs may have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance.	Not covered
b) Prescription Mail Service	Mail Order: Tier 1 Prescription Drugs: o $45 copayment for each prescription and/or refill up to a maximum ninety (90) day supply. Tier 2 Prescription Drugs: After a $7,500 per member per calendar year Tier 2 and Tier 3 Prescription Drug Deductible is satisfied: o $120 copayment for each prescription and/or refill up to a maximum ninety (90) day supply. Tier 3 Prescription Drugs: After a $7,500 per member per calendar year Tier 2 and Tier 3 Prescription Drug Deductible is satisfied: o 50% coinsurance for each prescription and/or refill up to a maximum ninety (90) day supply.	Not covered

	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUGS[6] Level of coverage and restrictions on prescriptions (continued)	Tier 2 and Tier 3 Prescription Drug Deductible Each member must meet a Tier 2 and Tier 3 Prescription Drug Deductible amount of $7,500 each Year. This Deductible is separate from the annual Deductibles for medical benefits and does not accumulate towards satisfying the medical In-Network or Out-of-Network Provider Deductibles. This Tier 2 and Tier 3 Prescription Drug Deductible applies to Tier 2 and Tier 3 Prescription Drugs purchased at Participating Pharmacies and through the Mail Order Prescription Drug Program. Note: • Copayments for the Tier 2 and Tier 3 deductible will not accumulate towards the Tier 3 Specialty Prescription Drug Coinsurance Maximum and will continue to be required even after the Tier 3 Specialty Prescription Drug Coinsurance Maximum has been reached. • The Tier 2 and Tier 3 Drug Deductible will not accumulate to satisfy the Tier 3 Specialty Prescription Drug Coinsurance Maximum. Tier 3 Specialty Prescription Drug Coinsurance Maximum: There is a $2,500 Tier 3 Out-of-Pocket Maximum for specialty prescription drugs per member per calendar year when purchased from preferred specialty pharmacies. You will not be required to pay more than $2,500 per calendar year for specialty prescription drugs purchased from preferred specialty pharmacies. Once the $2,500 Tier 3 Out-of-Pocket Maximum is met, no further copayments or coinsurance will be required for covered specialty prescriptions obtained from preferred specialty pharmacies, for the remainder of that calendar year. Note: Specialty drugs are only available through Anthem's specialty pharmacy benefit manager. Note: • Copayments for Tier 1 and Tier 2 drugs will not accumulate towards the Tier 3 Prescription Drug Coinsurance Maximum, and will continue to be required even after the Tier 3 Prescription Drug Coinsurance Maximum has been reached. • The Tier 2 and 3 Prescription Drug Deductible does not accumulate to satisfy the Tier 3 Specialty Prescription Drug Coinsurance Maximum. • The Tier 3 Specialty Prescription Drug Coinsurance Maximum does not accumulate towards satisfying the medical In-Network and Out-of-Network Medical Out-of-Pocket Annual Maximum. Prescription drug expenses do not apply towards the Out of Pocket maximum for medical benefits. Drugs obtained from pharmacies outside the United States will not be covered unless such drugs are prescribed in connection with Emergency. Non-Formulary Prescription Drugs: Charges for non-formulary prescription drugs will not be applied towards the Prescription Drug Deductible or the Tier 2 and Tier 3 Out-of-Pocket Maximum. • 100% of the contracted amount if purchased from a participating pharmacy. • 100% of the cash price if purchased from a non-participating pharmacy. Benefits for orally administered cancer chemotherapy will not be less favorable than the benefits for cancer chemotherapy that is administered intravenously or by injection. Oral chemotherapy must be found to be medically necessary by the treating physician for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in the terms of type, frequency, extent, site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider.	
12. INPATIENT HOSPITAL	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
13. OUTPATIENT/AMBULATORY SURGERY	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
14. DIAGNOSTICS a) Laboratory & x-ray	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) MRI, nuclear medicine, and other high-tech services	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Breast cancer screening with mammography in accordance with the "A" and "B" recommendations of the U.S. Preventive Services Task Force. Notwithstanding the "A" and "B: recommendations of the Task Force, an annual breast cancer screening with mammography shall be covered for all individuals with at least one risk factor.	
15. EMERGENCY CARE[7, 8]	30% coinsurance after deductible.	30% coinsurance after deductible.
16. AMBULANCE In the event of a medical emergency a) Ground	30% coinsurance after deductible.	30% coinsurance after deductible.
b) Air	30% coinsurance after deductible.	30% coinsurance after deductible.
Other than in a medical emergency a) Ground	30% coinsurance after deductible	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) Air	30% coinsurance after deductible	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
19. 0THER MENTAL HEALTH CARE a) Inpatient care	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) Outpatient care	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Anthem will cover benefits up to a maximum of forty (40) days per member per calendar Year, in- and out-of-network providers combined professional services.	
20. ALCOHOL & SUBSTANCE ABUSE	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Inpatient rehabilitation: Anthem will cover benefits up to a maximum of twenty (20) days, in- and out-of-network combined, per calendar year for inpatient rehabilitation for treatment of alcohol or drug abuse. Counseling: Anthem will pay benefits up to twenty (20) outpatient visits, in- and out-of-network combined, per calendar year for alcohol and drug abuse treatment.	

	IN-NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY a) Inpatient	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Covered for inpatient rehabilitation therapy for up to thirty (30) days per member in each calendar year in- and out-of-network combined.	
b) Outpatient	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Limited to twenty-four (24) visits per calendar year for physical therapy, occupational therapy, and/or chiropractic therapy; in- and out-of-network combined. Speech therapy is limited to twenty (20) visits per member in each calendar year in- and out-of-network combined.	
22. OUTPATIENT THERAPY FOR CONGENITAL DEFECTS AND BIRTH ABNORMALITLES	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Benefits are available up to a member's 6th birthday, limited to twenty (20) visits each for physical therapy, occupational therapy and/or speech therapy per calendar year; in- and out-of-network combined.	
23. DURABLE MEDICAL EQUIPMENT	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	For prosthetic devices (arms and legs), benefits are at least equal to those benefits provided under federal law for health insurance for the aged and disabled, if applicable. Prosthetics charges will not count toward any applicable annual durable medical equipment maximum amount, if any. Wigs are covered up to a maximum Anthem payment of $500 per member per calendar year combined in and out-of-network, with a doctor's prescription. Footwear for diabetes is limited to a $400 maximum Anthem payment per calendar year, in- and out-of-network combined.	
24. OXYGEN	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
25. ORGAN TRANSPLANTS	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
26. HOME HEALTH CARE	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Limited to sixty (60) visits per member each calendar year, in- and out-of-network combined up to four (4) hours or less each visit. Includes Private Duty Nursing when medically necessary and approved by Anthem.	

	IN-NETWORK	OUT-OF-NETWORK
27. HOSPICE CARE a) Inpatient Care	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) Outpatient care	30% coinsurance after deductible.	50% coinsurance, plus all charges in excess of the maximum allowed amount.
	A benefit period is 91 days. Anthem will cover up to 91-days for routine home care services per benefit period up to three benefit periods, in- and out-of-network combined. Anthem will allow up to $1,400 for Bereavement support services for the covered family members during the twelve-month period following the death of the member. Please see the Hospice section in your certificate for a description of covered services.	
28. SKILLED NURSING FACILITY CARE	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Benefits are limited to one hundred (100) days per member per year, in– and out-of-network combined.	
29. DENTAL CARE	Not covered	Not covered
30. VISION CARE	Not covered	Not covered
31. CHIROPRACTIC CARE	Covered under PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY (see line 21).	Covered under PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY (see line 21).
32. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Members who desire another professional opinion may obtain a second surgical opinion. For treatment by a physician or dentist of an Accidental Injury to the natural teeth, if the injury occurs while you are covered under the Agreement, and the services are received within six months of the injury.	

PART C: LIMITATIONS AND EXCLUSIONS

33. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED. [10]	12 months for all pre-existing conditions unless the covered person is a HIPAA-eligible individual as defined under federal and state law or under age 19, in which case there are no pre-existing condition exclusions.
34. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No.
35. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Members under the age of 19 will not be subject to benefit exclusions or limitations for a health condition that is considered to be pre-existing condition. For members age 19 and older, a pre-existing condition is an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health-care professional, or took prescription drugs within 12 months immediately preceding the effective date of coverage.
36. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
37. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
38. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining preauthorization.	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
39. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
40. What is the main customer service number?	(888) 231-5046	
41. Whom do I write/call if I have a complaint? Whom do I write if I want to file a grievance?[11]	Anthem Customer Service Department P.O. Box 5747, Denver, CO 80217-5747 (888) 231-5046 Anthem Quality Management 700 Broadway – MC 0532, Denver, CO 80273	
42. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance, ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202	
43. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form # MCOCN636A, individual	
44. Does the plan have a binding arbitration clause?	Yes	

[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

[2] "Deductible Type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as a "Per Accident or Injury" or "Per Confinement."

[2a] "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., a calendar year or benefit year) before the carrier will cover those expenses. The specific expenses that are subject to deductible may vary by policy. Expenses that are subject to deductible should be noted in boxes 8 through 31.

[2b] "Individual" means the deductible amount you and each individual covered by a non-HSA qualified policy will have to pay for allowable covered expenses before the carrier will cover those expenses. "Single" means the deductible amount you will have to pay for allowable covered expenses under an HSA-qualified health plan when you are the only individual covered by the plan.

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid. Note: Family coverage is not provided under this policy.

[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, including outpatient psychotherapy visits for biologically based mental illness.

[5] Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother if complication of pregnancy and well-baby together: there are not separate copayments.

[6] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

[7] "Emergency care" means all services delivered in an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb threatening emergency existed.
[8] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

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

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

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

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

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

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

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

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

Cancer Screenings

At Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Colorado, Inc., we believe cancer screenings provide important preventive care that supports our mission: to improve the lives of the people we serve and the health of our communities. We cover cancer screenings as described below.

Pap Tests

Payment for an annual Pap test is based on the plan's laboratory services provisions, and payment for the related office visit is based on the plan's preventive care provisions..

Mammogram Screenings

All plans except our HMO and PPO Basic Health provide mammogram screening coverage for women in accordance with the "A" and "B" recommendations of the U.S. Preventive Services Task Force. Frequency guidelines can be found in your certificate. Payment for the mammogram screening benefit is based on the plan's provisions for X-ray services.

Prostate Cancer Screenings

All plans except our HMO and PPO Basic Health Plans provide prostate cancer screening coverage for men 40 years of age and older. Frequency guidelines can be found in your certificate. Payment for the prostate cancer screening benefit is based on the plan's provisions for X-ray services.

Colorectal Cancer Screenings

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

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

NOTE: For GF and NGF. As noted above in this disclaimer, this summary does not apply to HMO plans and ASO plans.