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MTN Health Insurance, LLC

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

Name of Carrier

**Tonik for Individuals \$3,000**

Name of Plan

**PART A: TYPE OF COVERAGE**

<b>1. TYPE OF PLAN</b>	Preferred provider plan
<b>2. OUT-OF-NETWORK CARE COVERED?<sup>1</sup></b>	Yes, but the patient pays more for out-of-network care
<b>3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE</b>	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.

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>4. ANNUAL DEDUCTIBLE<sup>2</sup></b>		
<b>a) Individual</b>	\$3,000 per calendar year which is the out-of-pocket maximum for in-network providers and applies to your out-of-pocket maximum, combined in-network and out-of-network. The first four office visits, emergency room visits, ambulance services, certain routine vision benefits and certain preventive care services are not subject to your deductible. Some copayments and coinsurance will not be applied to your deductible.	\$3,000 per calendar year which applies to your out-of-pocket maximum for out-of-network providers, combined in-network and out-of-network. The first four office visits, emergency room visits, ambulance services, certain routine vision benefits and certain preventive care services are not subject to your deductible. Some copayments and coinsurance will not be applied to your deductible.
<b>b) Family</b>	Family coverage not provided	Family coverage not provided
<b>5. OUT-OF-POCKET ANNUAL MAXIMUM<sup>3</sup></b>		
<b>a) Individual</b>	\$3,000 which is your deductible amount per calendar year, some copayments and coinsurance will not be applied toward your out-of-pocket annual maximum, for these services you will continue to pay copayments and coinsurance even after you out-of-pocket annual maximum has been satisfied. See policy for types and circumstances of coverage.	\$10,000 per calendar year, some copayments and coinsurance will not be applied toward your out-of-pocket annual maximum, for these services you will continue to pay copayments and coinsurance even after you out-of-pocket annual maximum has been satisfied. See policy for types and circumstances of coverage.
<b>b) Family</b>	Family coverage not provided	Family coverage not provided
<b>c) Is deductible included in the out-of-pocket maximum?</b>	Yes	Yes

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE</b>	<p>\$5,000,000 combined in-network and out-of-network.</p> <p>Bariatric surgery has a lifetime maximum payment by the carrier of \$7,500 per member for services received from a Center of Excellence facility or a lifetime maximum payment by the carrier of \$1,500 per member for services received from a facility that has not been designated as a Center of Excellence; total lifetime maximum payment by the carrier shall not exceed \$7,500 per member in-network and out-of-network combined. Programs to stop tobacco use have a lifetime reimbursement maximum of \$50 per member in-network and out-of-network combined.</p>	<p>\$5,000,000 combined in-network and out-of-network.</p> <p>Bariatric surgery has a lifetime maximum payment by the carrier of \$1,500 per member for services received from a facility that has not been designated as a Center of Excellence; total lifetime maximum payment by the carrier shall not exceed \$7,500 per member in-network and out-of-network combined. Programs to stop tobacco use have a lifetime reimbursement maximum of \$50 per member in-network and out-of-network combined.</p>
<b>7A. COVERED PROVIDERS</b>	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.
<b>7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?</b>	Yes	Yes

	IN-NETWORK	OUT-OF-NETWORK
<p><b>8. ROUTINE MEDICAL OFFICE VISITS<sup>4</sup></b></p> <p><b>a) Primary Care Providers</b></p>	<p>\$30 copayment per office visit for the first four office visits in a calendar year combined between primary care providers, specialists, in-network and out-of-network providers. Services are not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum), for all other covered services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 100%. Certain diagnostic x-ray and laboratory services are not included in the payment, see line 14. After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you do not pay any copayment or coinsurance for office visits for the remainder of that calendar year.</p>	<p>40% coinsurance, not subject to deductible for the first four office visits in a calendar year combined between primary care providers, specialists, in-network and out-of-network providers (coinsurance does not apply to deductible or out-of-pocket annual maximum). After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you pay 40% coinsurance for office visits for the remainder of that calendar year.</p>
<p><b>b) Specialists</b></p>	<p>\$30 copayment per office visit for the first four office visits in a calendar year combined between primary care providers, specialists, in-network and out-of-network providers. Services are not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum), for all other covered services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 100%. Certain diagnostic x-ray and laboratory services are not included in the payment, see line 14. After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you do not pay any copayment or coinsurance for office visits for the remainder of that calendar year.</p>	<p>40% coinsurance, not subject to deductible for the first four office visits in a calendar year combined between primary care providers, specialists, in-network and out-of-network providers (coinsurance does not apply to deductible or out-of-pocket annual maximum). After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you pay 40% coinsurance for office visits for the remainder of that calendar year.</p>

	IN-NETWORK	OUT-OF-NETWORK
<p><b>9. PREVENTIVE CARE</b></p> <p><b>a) Children's services</b></p>	<p>\$30 copayment per office visit for the first four office visits in a calendar year combined between primary care providers, specialists, in-network and out-of-network providers. Services are not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum), for all other covered services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 100%. Certain diagnostic x-ray and laboratory services are not included in the payment, see line 14. After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you do not pay any copayment or coinsurance for office visits for the remainder of that calendar year.</p>	<p>40% coinsurance, not subject to deductible for the first four office visits in a calendar year combined between primary care providers, specialists, in-network and out-of-network providers (coinsurance does not apply to deductible or out-of-pocket annual maximum). After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you pay 40% coinsurance for office visits for the remainder of that calendar year.</p>
<p><b>b) Adults' services</b></p>	<p>\$30 copayment per office visit for the first four office visits in a calendar year combined between primary care providers, specialists, in-network and out-of-network providers. Services are not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum), for all other covered services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 100%. Certain diagnostic x-ray and laboratory services are not included in the payment, see line 14. After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you do not pay any copayment or coinsurance for office visits for the remainder of that calendar year.</p>	<p>40% coinsurance, not subject to deductible for the first four office visits in a calendar year combined between primary care providers, specialists, in-network and out-of-network providers (coinsurance does not apply to deductible or out-of-pocket annual maximum). After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you pay 40% coinsurance for office visits for the remainder of that calendar year.</p>
<p><b>10. MATERNITY</b></p> <p><b>a) Prenatal care</b></p>	<p>Not covered</p>	<p>Not covered</p>
<p><b>b) Delivery &amp; inpatient well baby care<sup>5</sup></b></p>	<p>Routine delivery not covered, this plan only covers complications of pregnancy. No copayment 100% covered after deductible for inpatient well baby care for 31-days following birth, adoption or placement for adoption.</p>	<p>Routine delivery not covered, this plan only covers complications of pregnancy. 40% coinsurance after deductible for inpatient well baby care for 31-days following birth, adoption or placement for adoption.</p>

	IN-NETWORK	OUT-OF-NETWORK
<b>11. PRESCRIPTION DRUGS<sup>6</sup></b> <b>Level of coverage and restrictions on prescriptions</b> <b>a) Outpatient care</b>  <b>b) Prescription Mail Service</b>	<p>Generic formulary drugs \$10 copayment or 30% of the negotiated fee for self-injectable drugs at a participating pharmacy up to a 34-day supply. Prescription generic drugs listed on the formulary are covered.</p> <p>Generic formulary drugs \$20 copayment or 30% of the negotiated fee for self-injectable drugs through the mail order service up to a 90-day supply. Prescription generic drugs listed on the formulary are covered.</p> <p>For drugs on our approved list, contact Customer Service at 1-800-317-9818. Covered only when received from a participating pharmacy.</p>	<p>Not covered</p> <p>Not covered</p>
<b>12. INPATIENT HOSPITAL</b>	No copayment 100% covered after deductible	40% coinsurance after deductible
<b>13. OUTPATIENT/AMBULATORY SURGERY</b>	No copayment 100% covered after deductible	40% coinsurance after deductible
<b>14. DIAGNOSTICS</b> <b>a) Laboratory &amp; x-ray</b>  <b>b) MRI, nuclear medicine and other high-tech services</b>	<p>No copayment 100% covered after deductible</p> <p>No copayment 100% covered after deductible</p>	<p>40% coinsurance after deductible</p> <p>40% coinsurance after deductible</p>
<b>15. EMERGENCY CARE<sup>7,8</sup></b>	\$100 copayment per visit, not subject to deductible (copayment for does not apply to deductible or out-of-pocket annual maximum).	\$100 copayment per visit, not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum), for participating providers or \$100 copayment per visit for non-participating providers plus you pay 40% coinsurance not subject to deductible (amounts paid do not apply to deductible or out-of-pocket annual maximum).
<b>16. AMBULANCE</b>	\$100 copayment per day for ground and/or air ambulance services, not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum).	\$100 copayment per day for ground and/or air ambulance services, not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum).

	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>17. URGENT, NON-ROUTINE, AFTER HOURS CARE</b>	\$30 copayment per office visit for the first four office visits in a calendar year combined between primary care providers, specialists, routine medical office visits, in-network and out-of-network providers. Services are not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum), for all other covered services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 100%. Certain diagnostic x-ray and laboratory services are not included in the payment, see line 14. After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you do not pay any copayment or coinsurance for office visits for the remainder of that calendar year.	40% coinsurance, not subject to deductible for the first four office visits in a calendar year combined between primary care providers, specialists, routine medical office visits, in-network and out-of-network providers (coinsurance does not apply to deductible or out-of-pocket annual maximum). After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you pay 40% coinsurance for office visits for the remainder of that calendar year.
<b>18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE<sup>9</sup></b>	Biologically-Based Mental Illness Care is paid as Other Mental Health Care, see line 19.	Biologically-Based Mental Illness Care is paid as Other Mental Health Care, see line 19.
<b>19. OTHER MENTAL HEALTH CARE</b>		
<b>a) Inpatient care</b>	You pay all charges except for \$175 per day (amounts paid do not apply to out-of-pocket annual maximum). Benefits are limited to a maximum Anthem payment of \$5,250 per calendar year with a maximum of 30 days per calendar year combined in-network and out-of-network.	You pay all charges except for \$175 per pay (amounts paid do not apply to out-of-pocket annual maximum). Benefits are limited to a maximum Anthem payment of \$5,250 per calendar year with a maximum of 30 days per calendar year combined in-network and out-of-network.
<b>b) Outpatient care</b>	You pay all charges except for \$25 per visit (amounts paid do not apply to out-of-pocket annual maximum). Benefits are limited to 20 visits per calendar year combined in-network and out-of-network.	You pay all charges except for \$25 per visit (amounts paid do not apply to out-of-pocket annual maximum). Benefits are limited to 20 visits per calendar year combined in-network and out-of-network.
<b>20. ALCOHOL &amp; SUBSTANCE ABUSE</b>	Not covered	Not covered
<b>21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY</b>	No copayment 100% covered after deductible. Benefits are limited to 12 visits per calendar year for physical therapy, occupational therapy and/or chiropractic therapy in-network and out-of-network combined. Benefits are limited to 50 visits per calendar year for speech therapy when following surgery, injury or non-congenital organic disease, in-network and out-of-network combined. For members up to age 5 with congenital defects and birth abnormalities see the policy for types and circumstance of coverage.	40% coinsurance after deductible for participating providers. For non-participating providers after deductible you pay all charges except \$25 per visit (amounts paid do not apply to the out-of-pocket annual maximum). Benefits are limited to 12 visits per calendar year for physical therapy, occupational therapy and/or chiropractic therapy in-network and out-of-network combined. Benefits are limited to 50 visits per calendar year for speech therapy when following surgery, injury or non-congenital organic disease, in-network and out-of-network combined. For members up to age 5 with congenital defects and birth abnormalities see the policy for types and circumstance of coverage.
<b>22. DURABLE MEDICAL EQUIPMENT</b>	No copayment 100% covered after deductible. See policy for types and	40% coinsurance after deductible. See policy for types and circumstances of

	IN-NETWORK	OUT-OF-NETWORK
	circumstances of coverage. For prosthetic devices (arms and legs), benefits are provided with the same deductible and coinsurance as provided by Medicare.	coverage. For prosthetic devices (arms and legs), benefits are provided with the same deductible as provided by Medicare.
23. OXYGEN	No copayment 100% covered after deductible.	40% coinsurance after deductible
24. ORGAN TRANSPLANTS	Inpatient – No copayment 100% covered after deductible Outpatient - \$30 copayment per office visit for the first four office visits in a calendar year combined between primary care providers, specialists, routine medical office visits, in-network and out-of-network providers. Services are not subject to deductible (copayment does not apply to deductible or out-of-pocket annual maximum), for all other covered services which are part of the office visit (e.g., laboratory and x-ray services) plan pays 100%. Certain diagnostic x-ray and laboratory services are not included in the payment, see line 14. After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you do not pay any copayment or coinsurance for office visits for the remainder of that calendar year.	Inpatient - 40% coinsurance after deductible  Outpatient – 40% coinsurance, not subject to deductible for the first four office visits in a calendar year combined between primary care providers, specialists, routine medical office visits, in-network and out-of-network providers (coinsurance does not apply to deductible or out-of-pocket annual maximum). After four office visits in a calendar year you pay all charges until your deductible has been satisfied. After your deductible has been satisfied you pay 40% coinsurance for office visits for the remainder of that calendar year.
25. HOME HEALTH CARE	No copayment 100% covered after deductible. Benefits are limited to 60 visits per calendar year in-network and out-of-network combined.	40% coinsurance after deductible. Benefits are limited to 60 visits per calendar year in-network and out-of-network combined.
26. HOSPICE CARE	No copayment 100% covered after deductible. Benefits for routine home care are limited to a maximum Anthem payment of \$100 per day in-network and out-of-network combined.	40% coinsurance after deductible. Benefits for routine home care are limited to a maximum Anthem payment of \$100 per day in-network and out-of-network combined.
27. SKILLED NURSING FACILITY CARE	Not covered	Not covered
28. DENTAL CARE	Dental benefits included in this plan can be found on the separate Dental Summary Description.	
29. VISION CARE	Reimbursement of up to \$50 per calendar year not subject to deductible for such services as routine eye exam, eyeglasses or contact lenses, in-network and out-of-network combined.	Reimbursement of up to \$50 per calendar year not subject to deductible for such services as routine eye exam, eyeglasses or contact lenses, in-network and out-of-network combined.
30. CHIROPRACTIC CARE	See line 21.	See line 21.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	<b>Program to Stop Tobacco Use:</b> Reimbursement of up to \$50 per lifetime in-network and out-of-network combined. <b>Second Opinion:</b> Members who desire another professional opinion, may obtain a second opinion.	<b>Program to Stop Tobacco Use:</b> Reimbursement of up to \$50 per lifetime in-network and out-of-network combined. <b>Second Opinion:</b> Members who desire another professional opinion, may obtain a second opinion.

**PART C: LIMITATIONS AND EXCLUSIONS**

32. <b>PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.<sup>10</sup></b>	12 months for all pre-existing conditions unless the covered person is a HIPAA-eligible individual as defined under federal and state law, in which case there are no pre-existing condition exclusions.
33. <b>EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?</b>	Yes, unless the individual is a HIPAA-eligible individual as defined under federal and state law.
34. <b>HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?</b>	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.
35. <b>WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?</b>	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan, sponsor (e.g., employer). Review the list 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. <b>Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?</b>	No	Yes, the member is responsible for obtaining prior authorization unless the provider participates with Anthem Blue Cross and Blue Shield. If prior authorization is not obtained the member is responsible for an additional \$250 copayment for services from a non-participating provider. This \$250 copayment does not apply to your out-of-pocket annual maximum.
37. <b>Is prior authorization required for surgical procedures and hospital care (except in an emergency)?</b>	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining the prior authorization.	Yes, the member is responsible for obtaining prior authorization unless the provider participates with Anthem Blue Cross and Blue Shield.
38. <b>If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b>	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield Non-Participating Providers have not signed agreements with Anthem. You will pay a much greater share of the cost for covered services when you receive services from them. They may charge you whatever they like, but we will pay benefits based only on the amount we that we will allow for non-participating providers which is subject to the maximum benefit allowance. You will be responsible for any balance of a non-participating provider's bill which is above the maximum benefit allowance for non-participating providers, in addition to any other copayments, coinsurance and deductible.
39. <b>What is the main customer service number?</b>	1-800-317-9818	
40. <b>Whom do I write/call if I have a complaint or want to file a grievance?<sup>11</sup></b>	Anthem Blue Cross and Blue Shield Complaints and Appeals 700 Broadway, Denver, CO 80273 1-800-317-9818	
41. <b>Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?</b>	<b>Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202</b>	
42. <b>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.</b>	Policy form #'s 98884, individual	
43. <b>Does the plan have a binding arbitration clause?</b>	Yes	

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

<sup>2</sup> “Deductible” 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) 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 may be noted in boxes 8 through 31.

<sup>3</sup> “Out-of-pocket maximum” means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include the deductibles or copayments, depending on the contract for that plan. The specific deductibles or copayments included in the out-of-pocket maximum may vary by policy. Expenses that are applied toward the out-of-pocket maximum may be noted in boxes 8 through 31.

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

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

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

<sup>7</sup> “Emergency care” means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb threatening emergency existed.

<sup>8</sup> Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

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

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

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

*An Anthem Company*

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

Colorado law requires carriers to make available a Colorado Health 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.

### **Individual Health Plans**

**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.**

### **Group Health Plans**

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

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

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

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

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

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

## **Cancer Screenings**

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

### **Pap Tests**

All plans except our BasicBlue PPO Plan provide coverage for an annual Pap test and the related office visit. The BasicBlue PPO Plan provides coverage for a Pap test and the related office visit once every three years. Payment for the 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. With our BluePreferred for Individuals PPO Plan, laboratory services for a Pap test are limited to a maximum payment of \$75.00. With our Colorado HSA-Qualified Plans for Individuals, all services related to a Pap test are subject to the maximum benefit as described on the Health Plan Description Form. Under some plans pap tests received out of-network are not covered. Our BasicBlue PPO Plan does not provide coverage for Pap tests.

### **Mammogram Screenings**

All plans except our HMO and PPO Basic Health and BluePreferred for Individual Plans provide mammogram screening coverage for women. For BluePreferred for Individuals the following frequency guidelines apply: For women between the ages of 35 years and 40 years, a single baseline screening mammogram is covered. For women between 40 years of age and less than 50 years of age, a screening mammogram is covered once every two years, or it is covered annually if the member's physician has determined that identified breast cancer risk factors are present. For women between the ages of 50 years and 65 years, a screening mammogram is covered annually. Payment for the mammogram screening benefit is based on the plan's provisions for X-ray services. Our HMO and PPO Basic Health Plans do not provide coverage for mammogram screenings.

### **Prostate Cancer Screenings**

All plans except our HMO and PPO Basic Health Plans provide prostate cancer screening coverage for men. In all plans except our Tonik Plan the following frequency guidelines apply: For men between 40 years of age and less than 50 years of age, a prostate cancer screening is covered annually if the member's physician has determined that identified prostate cancer risk factors are present. For men 50 years of age and older, a prostate cancer screening is covered annually. Payment for the prostate cancer screening benefit is based on the plan's provisions for X-ray services. Our HMO and PPO Basic Health Plans do not provide coverage for prostate cancer screenings.

### **Colorectal Cancer Screenings**

Several types of colorectal cancer screening methods exist. All plans except BluePreferred for Individual 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. Under most plans colorectal cancer screenings received out of-network are not covered.

The information above is only a summary of the benefits described. The certificate for each health plan includes important additional information about limitations, exclusions and covered benefits. The Health 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 Plan Description Form.