

## PART A: TYPE OF COVERAGE

**SCHEDULE OF BENEFITS (Who Pays What)**

**Anthem Blue Cross and Blue Shield**

**Name of Carrier**

# PPO $40 Copay

**Name of Plan**

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

## PART B: SUMMARY OF BENEFITS

**Important Note**: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require Precertification, prior authorization, a referral from your Primary Care Provider, 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.

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **4. Deductible Type2** | Calendar Year | Calendar Year |
| **4a. ANNUAL DEDUCTIBLE2a**  **a) Individual2b** | $500, excludes Copayments | $1,000 |
| **b) Family2c** | $1,000, excludes Copayments | $2,000 |
|  | 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 number of days, visits or dollar amounts allowed. 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 number of days, visits or dollar amounts allowed. 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 éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.**

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling member services at the number on the back of your Health Benefit ID Card.

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| 1. **OUT-OF-POCKET ANNUAL MAXIMUM3**    1. **Individual**    2. **Family**    3. **Is deductible included in the out-of-pocket maximum?** | $4,000 excludes Deductible and Copayments  $8,000, 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 allowed. These maximums apply even if the applicable Out-of-Pocket Annual Maximum is satisfied. | $8,000 excludes Deductible  $16,000, 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 allowed. 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, you will still be responsible for paying the difference between the Maximum Allowed Amount and the non-participating Providers Billed Charges (sometimes called “balance billing”).  The amounts you pay for Out-of-Network Covered Services are in addition to your balance billing costs. |
| **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. Bariatric surgery has a per occurrence maximum benefit of $7,500 per Member for services received from a designated Facility or a per occurrence maximum benefit of $1,500 per Member for services received from a facility that is not a designated Facility; total per occurrence maximum benefit shall not exceed $7,500 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. Bariatric surgery has a per occurrence maximum benefit of $1,500 per Member for services received from a Facility that is not a designated Facility; total per occurrence maximum benefit shall not exceed $7,500 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 Services. |
| **7B. With respect to network plans, are all the providers listed in 7A accessible to me through my Primary Care Provider?** | Yes | Yes |

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| 1. **MEDICAL OFFICE VISITS4**    1. **Primary Care Providers**    2. **Specialists** | $40 Copayment per office visit; no Coinsurance (100% covered) for all other services which are performed in the Doctor’s office and billed by the Doctor (e.g., laboratory and x-ray services). Services performed or billed by another Provider are not included in the visit Copayment, see line 14 for payment information. Excludes MRI, CT, PET scans, nuclear medicine and other high-tech services, see line 14.  $40 Copayment per office visit; no Coinsurance (100% covered) for all other services which are performed in the Doctor’s office and billed by the Doctor (e.g., laboratory and x-ray services). Services performed or billed by another Provider are not included in the visit Copayment, see line 14 for payment information. Excludes MRI, CT, PET scans, nuclear medicine and other high-tech services, see line 14. | You pay 50% after Deductible  You pay 50% after Deductible |
| 1. **PREVENTIVE CARE**    1. **Children’s services**    2. **Adults’ services** | Up to age 13, $40 Copayment per office visit. Copayment includes services provided as preventive care.  $40 Copayment per office visit. Copayment includes services provided as preventive care, including preventive Facility services.  Covered preventive services are not subject to Coinsurance or Deductible. | Up to age 13, $80 Copayment per office visit. Copayment includes services provided as preventive care.  $80 Copayment per office visit. Copayment includes services provided as preventive care. For covered preventive Facility services, you pay $500 Copayment.  Covered preventive services are not subject to Coinsurance or Deductible. |
| 1. **MATERNITY**    1. **Prenatal care**    2. **Delivery & inpatient well baby care5** | $40 Copayment for first prenatal care office visit/delivery from the Doctor; no Coinsurance (100% covered) for all other services which are performed in the Doctor’s office and billed by the Doctor (e.g., laboratory and x-ray services). Services performed or billed by another Provider are not included in the visit Copayment, see line 14 for payment information.  You pay 30% after Deductible | You pay 50% after Deductible  You pay 50% after Deductible |

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| **11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions6** | **Inpatient care** – Included with the inpatient Hospital benefit (see line 12) | **Inpatient care** – Included with the inpatient Hospital benefit (see line 12). |
|  | **Outpatient care Retail Pharmacy Drugs** - Tier 1 $20 Copayment, tier 2 $40 Copayment, tier 3 $50 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. | **Outpatient care Retail Pharmacy Drugs** - Not covered |
|  | **Outpatient care Specialty Pharmacy Drugs** - Tier 1 $20 Copayment, tier 2 $40 Copayment, tier 3 $50 copayment, tier 4 30% Copayment, per prescription up to a 30-day supply. For tier 4 Specialty Pharmacy Drugs the maximum Copayment per prescription is $250 per 30-day supply. Specialty Pharmacy Drugs are not available at a Retail Pharmacy or from a Home Delivery Pharmacy. | **Outpatient care Specialty Pharmacy Drugs** - Not covered |
|  | **Outpatient care Home Delivery Pharmacy Drugs** - Tier 1 $20 Copayment, tier 2 $80 Copayment, tier 3 $100 Copayment, tier 4 30% Copayment, per prescription through the Home Delivery Pharmacy up to a 90-day supply. For the tier 4 Home Delivery Pharmacy 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 Home Delivery Pharmacy. | **Outpatient care Home Delivery Pharmacy Drugs** - Not covered |
|  | **The following applies to outpatient retail Pharmacy Drugs, Specialty Pharmacy Drugs and Home Delivery Pharmacy Drugs:** Includes coverage for smoking cessation prescription Legend Drugs when enrolled in a smoking cessation counseling program approved by Anthem. | 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 need to pay for the cost difference between the Generic and Brand- Name Drug, in addition to your tier Copayment. The cost difference between the Generic and Brand Name Drug does not go towards your Out-of-Pocket Annual Maximum. By law, Generic and Brand-Name drugs must meet the same standards for safety, strength, and effectiveness. We reserve the right, at our discretion, to remove certain higher cost generic drugs from this policy. For drugs on our approved list, call member services at 877-833- 5734. |  |

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **12. INPATIENT HOSPITAL** | You pay 30% after Deductible | You pay 50% after Deductible |
| **13. OUTPATIENT/AMBULATORY SURGERY AT A FACILITY** | You pay 30% after Deductible | You pay 50% after Deductible |
| 1. **DIAGNOSTICS**    1. **Laboratory & x-ray**    2. **MRI, nuclear medicine, and other high-tech services** | You pay 30% after Deductible for laboratory or x-ray services which are not included in the applicable visit Copayment or that were billed on a different date than the office visit.  You pay 30% after Deductible | You pay 50% after Deductible  You pay 50% after Deductible |
| **15. EMERGENCY CARE7** | You pay 30% after Deductible | Out-of-Network care is paid as In Network |
| 1. **AMBULANCE**    1. **Ground**    2. **Air** | You pay 30% after Deductible You pay 30% after Deductible | Out-of-Network care is paid as In Network Out-of-Network care is paid as In Network |
| **17. URGENT, NON-ROUTINE, AFTER HOURS CARE** | $40 Copayment per visit; no Coinsurance (100% covered) for all other services which are performed in the Doctor’s office and billed by the Doctor (e.g., laboratory and x-ray services). Services performed or billed by another Provider are not included in the visit Copayment, see line 14 for payment information. Excludes MRI, CT, PET scans, nuclear medicine and other high-tech services, see line 14. | You pay 50% after Deductible |
| 1. **MENTAL HEALTH CARE**    1. **Inpatient care**    2. **Outpatient 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.  You pay 30% after Deductible, subject to any applicable cost-share maximums imposed by law.  Up to $40 Copayment per office visit, subject to any applicable cost-share maximums imposed by law. | 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.  You pay 50% after Deductible, subject to any applicable cost-share maximums imposed by law.  You pay 50% after Deductible, subject to any applicable cost-share maximums imposed by law. |
| **19. ALCOHOL & SUBSTANCE ABUSE** | **Inpatient care** – You pay 30% after Deductible, subject to any applicable cost-share maximums imposed by law.  **Outpatient care** – Up to $40 Copayment per office visit, subject to any applicable cost-share maximums imposed by law. | **Inpatient care** – You pay 50% after Deductible, subject to any applicable cost-share maximums imposed by law.  **Outpatient care** – You pay 50% after Deductible, subject to any applicable cost-share maximums imposed by law. |

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **20. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY** | **Inpatient care** – You pay 30% after Deductible. Up to 30 inpatient rehab days per calendar year In and Out-of-Network combined.  **Outpatient care** – You pay 30% 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. | **Inpatient care** – You pay 50% after Deductible. Up to 30 inpatient rehab days per calendar year In and Out-of-Network combined.  **Outpatient care** – You pay 50% 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. |
| **21. DURABLE MEDICAL EQUIPMENT** | You pay 30% after Deductible | Not covered |
| **22. OXYGEN** | You pay 30% after Deductible | Not covered |
| **23. ORGAN TRANSPLANTS** | **Inpatient care** – You pay 30% after Deductible  **Outpatient care** – $40 Copayment per visit; no Coinsurance (100% covered) for all other services which are performed in the Doctor’s office and billed by the Doctor (e.g., laboratory and x-ray services). Services performed or billed by another Provider are not included in the visit Copayment, see line 14 for payment information. Excludes MRI, CT, PET scans, nuclear medicine and other high-tech services, see line 14.  Transportation and lodging services are limited to a maximum benefit of $10,000 per Transplant Benefit Period; unrelated donor searches are limited to a maximum benefit of  $30,000 per Transplant Benefit Period. | **Inpatient care** – Not covered  **Outpatient care** – Not covered |
| **24. HOME HEALTH CARE** | You pay 30% after Deductible. Up to 100 visits per calendar year. | Not covered |
| **25. HOSPICE CARE** | You pay 30% after Deductible | You pay 50% after Deductible |
| **26. SKILLED NURSING FACILITY CARE** | You pay 30% after Deductible. Up to 100 days per calendar year In and Out-of-Network combined. | You pay 50% after Deductible. Up to 100 days per calendar year In and Out-of-Network combined. |
| **27. DENTAL CARE** | Not covered | Not covered |
| **28. VISION CARE** | Not covered | Not covered |
| **29. CHIROPRACTIC THERAPY** | $20 Copayment per visit, for all other services which are performed in the Provider’s office and billed by the Provider (e.g., laboratory and x-ray services). Services performed or billed by another Provider are not included in the visit Copayment, see line 14 for payment information. Up to 20 visits per calendar year combined with massage therapy and acupuncture/nerve pathway therapy, regardless of which type Provider renders the therapy. | Not covered |

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **30. SIGNIFICANT ADDITIONAL COVERED SERVICES** | **Other Covered Services**  **Massage Therapy, Acupuncture/Nerve Pathway Therapy**  $20 Copayment per visit, no Coinsurance (100% covered) for all other services which are performed in the Provider’s office and billed by the Provider (e.g., laboratory and x-ray services). Services performed or billed by another Provider are not included in the visit Copayment, see line 14 for payment information. Up to 20 visits per calendar year combined with chiropractic therapy, regardless of which type Provider renders the therapy.  **Nutritional Therapy**  $20 Copayment per visit for Specialist. Up to 4 visits per calendar year.  **Hearing Aids**  Benefit level determined by place of service. Hearing aids are covered up to age 18. Initial and replacement hearing aids will be supplied every 5 years.  New hearing aid will be a covered service when alterations to your existing hearing aid cannot adequately meet your needs or be repaired.  **Applied Behavioral Analysis Services** Benefits are based on the setting in which Covered Services are received.  **General Information**  For any outpatient Covered Service not elsewhere listed, you pay Coinsurance after Deductible. For example, this includes chemotherapy and outpatient non-surgical Facility services. | **Other Covered Services**  **Massage Therapy, Acupuncture/Nerve Pathway Therapy**  Not covered  **Nutritional Therapy**  Not covered  **Hearing Aids**  Benefit level determined by place of service. Hearing aids are covered up to age 18. Initial and replacement hearing aids will be supplied every 5 years.  New hearing aid will be a covered service when alterations to your existing hearing aid cannot adequately meet your needs or be repaired.  **Applied Behavioral Analysis Services** Benefits are based on the setting in which Covered Services are received.  **General Information**  For any outpatient Covered Service not elsewhere listed, you pay Coinsurance after Deductible. For example, this includes chemotherapy and outpatient non-surgical Facility services. |

## PART C: LIMITATIONS AND EXCLUSIONS

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| **31. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.** | Not applicable; plan does not impose limitation periods for pre-existing conditions. |
| **32. EXCLUSIONARY RIDERS. Can an individual’s specific, pre-existing condition be entirely excluded from the policy?** | No |
| **33. HOW DOES THE POLICY DEFINE A “PRE- EXISTING CONDITION”?** | Not applicable; plan does not exclude coverage for pre-existing conditions. |
| **34. 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 the list to see if a service or treatment you may need is excluded from the policy. |

**PART D: USING THE PLAN**

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|  | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **35. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?** | No | No |
| **36. Is Precertification required for surgical procedures and hospital care (except in an emergency)?** | Yes, the Doctor who schedules the procedure or Hospital care is responsible for obtaining the Precertification. | Yes, the Member is responsible for obtaining Precertification. |
| **37. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?** | No | Yes, you will be responsible for paying the difference between the Maximum Allowed Amount and the non-participating Provider’s Billed Charges (sometimes called “balance billing”).  The amount you pay for Out-of-Network Covered Services are in addition to your balance billing costs. |
| **38. What is the main member service number?** | 877-833-5734 | 877-833-5734 |
| **39. Whom do I write/call if I have a complaint or want to file a grievance?** | 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 |
| **40. 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 |
| **41. 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 COSGPPOGF Group – Small Group | Policy form #’s COSGPPOGF Group – Small Group |
| **42. 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 30.

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.

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

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 that 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.

**Grandfathered Health Plan**

Anthem Blue Cross and Blue Shield and HMO Colorado believes this is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered plan means that your Booklet may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

# 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. 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 routine screening or diagnostic mammogram regardless of age. Payment for the mammogram screening benefit is based on the plan’s provisions for preventive care.

## Prostate Cancer Screenings

All plans provide coverage under the preventive care benefits for routine prostate cancer screening for men. Payment for the prostate cancer screening is based on the plan’s provisions for preventive care.

## 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 is based on the plan’s provisions for preventive care.

**NOTICE OF PROTECTION PROVIDED BY**

**LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION**

This notice provides a **brief summary** of the Life and Health Insurance Protection Association (“the Association”) and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

* Life Insurance
  + $300,000 in death benefits
  + $100,000 in cash surrender or withdrawal values
* Health Insurance
  + $500,000 in hospital, medical and surgical insurance benefits
  + $300,000 in disability insurance benefits
  + $300,000 in long-term care insurance benefits
  + $100,000 in other types of health insurance benefits
* Annuities
  + $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is

$300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association’s website [www.colifega.org,](http://www.colifega.org/) email [jwrhodes@colifega.org](mailto:jwrhodes@colifega.org) or contact:

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| *Colorado Life and Health Insurance Protection* | *Colorado Division of Insurance* |
| *Association* | 1560 Broadway, Suite 850 |
| 201 Robert S. Kerr Ave. Suite 600 | Denver, CO 80202 |
| Oklahoma City, OK 73102 | (303) 894-7499 |
| 1-800-337-7796 |  |

## Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.