Anthem
Health. **Join In.**

Individual and Family Health Care Plans
for **Colorado**

Our plans fit your plans

ClearProtection℠
CoreShare℠ Plus

COBR20004CCP Rev. 9/11

Why do you need health care coverage?

These days, an average stay in the hospital can cost more than $20,000.* The financial risk you take without health coverage just isn't worth it. Not only does health coverage help you stay healthy, it also gives you added security, because you know you're protected against the high cost of unexpected medical bills.

Our plans fit the way you live.

In a world that's constantly changing, one thing's for certain: it's important to have health care coverage you can depend on – coverage designed to help fit your budget, and your way of life.

For over 30 years, Anthem has provided health care coverage and security to our Colorado neighbors. And now, we're pleased to offer these same individual health care plans with added benefits and features of the Affordable Health Care Act.

You're in charge of your health and budget, and our Individual health care plans help keep it that way. We offer a wide range of valuable coverage options as unique as you are. And if you have any questions, we're here to help.

Experience you can rely on

Anthem is committed to helping simplify your life and improving your health. That's why we offer:

- **One of the largest provider networks in Colorado.** With nearly 7,500 doctors and over 75 hospitals throughout the state, chances are your doctor is one of ours.
- **A choice of plans to fit your budget and lifestyle.** No matter where you are in life, we've got a plan designed to fit your health coverage needs, as well as your budget.
- **Optional dental and term life insurance.** To enhance your health and your family's financial future, we also offer dental and term life coverage and make it easy to enroll.
- **Coverage that travels with you.** No matter where life takes you, your health coverage goes with you. And the BlueCard® program makes it easy to access providers throughout the country.

* Based on 2008 weighted national estimates from HCUP National Inpatient Sample (NIS), Agency for Healthcare Research and Quality (AHRQ), based on data collected by Individual states and provided to AHRQ by the states. (Average stay of 3.8 days; average cost to uninsured of $22,512.)

Some definitions so we're all on the same page

Network Discounts: With Anthem Blue Cross and Blue Shield you have access to one of the largest provider networks in the state. These network (or participating) providers have agreed to accept lower costs for their covered services to Anthem members — similar to volume discounts. These negotiated costs help reduce the overall cost of covered medical services, including your share of those costs.

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With nearly 7,500 doctors and more than 75 hospitals, chances are your provider already participates. Just visit a network provider to take advantage of the savings.

With our PPO plans, you can always choose to receive services outside the network, but your share of the cost will be greater.*

Cost-Sharing: The costs of medical care today can be staggering. Health care coverage from Anthem Blue Cross and Blue Shield can help protect you against these high costs. With most health care coverage, you pay a monthly premium, then you share some of the cost of covered medical care with the company that provides your health care coverage. The level of cost-sharing you choose directly impacts your premium amount. The more you are willing to share in the costs, the lower your premium. With Anthem, you can choose your level of protection and the level of cost-sharing that works best for your health care needs and budget.

Deductible is the amount you have to pay each calendar year (annually) for covered services before your health care plan starts paying. For some services, the plan will even begin to pay before the deductible is met. Usually, the higher a plan's deductible, the lower the premium. In some cases, you may also have a separate deductible for certain services such as prescription drugs.

Coinsurance is the percentage of the cost of covered services that you will be responsible for, after your annual deductible is met. With some plans, you have a choice of coinsurance levels. Much like your deductible, selecting a higher coinsurance typically lowers your monthly premium because it increases your share of the cost.

Copayment (or Copay) is a specific dollar amount you have to pay for certain covered services.

Out-Of-Pocket Maximum is the most that you would pay in a calendar year for deductible and coinsurance for network covered services. Once you reach this maximum, the plan pays at 100% for most services for the rest of the calendar year.

Prescription Drugs are medications that must be authorized for use by your doctor. Anthem offers varying levels of prescription drug coverage. Depending on the plan, you may have coverage for generic drugs or generic and brand name drugs.

Generic Drugs are prescription drugs that typically have been in use for some time and can be manufactured and distributed by numerous companies, so their cost is usually much lower. Generic drugs must, by law, contain the same active ingredients as their brand name equivalent and have the same clinical benefit.

Brand Name Drugs are prescription drugs that are manufactured and marketed under a registered name. They are usually patented and may be exclusively offered by certain manufacturers.

Specialty Drugs are typically high cost, scientifically engineered drugs used to treat complex, chronic conditions. They require special handling and usually must be shipped directly to the user.

Formulary is a list of prescription drugs our health care plans cover. They include generic, brand name, and specialty drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans.

***Unlike participating providers, non-participating providers may send you a bill and collect for the amount of the provider's charge that exceeds the maximum allowed amount. Customer service is available to assist you in determining your plan's maximum allowed amount for a particular service from a non-participating provider.**

ClearProtection℠ Is this the right plan for you?

ClearProtection is one of our lower-priced plans with an innovative plan design that helps limit your share of the costs for major medical expenses, such as surgery and hospitalizations. In addition:

- You'll have immediate benefits for your first two doctors' office visits.
- There are two deductibles that work together to help you meet your out-of-pocket maximum.
- Once your out-of-pocket maximum is met, the plan pays 100% of the costs for most network covered services.

ClearProtection Plan Highlights

This plan offers a valuable combination of affordable coverage with some immediate benefits, plus a broad range of benefits once the out-of-pocket maximum is met.

Features:

- Some of our lowest monthly rates and immediate coverage for first two doctors' office visits.
- Access to discounts on ALL covered services from network providers while meeting your out-of-pocket maximum.
- 100% coverage for most network covered services once your out-of-pocket maximum is met.
- Coverage for generic and brand name prescription drugs.
- Preventive care benefits help focus on keeping you healthy.

You should know:

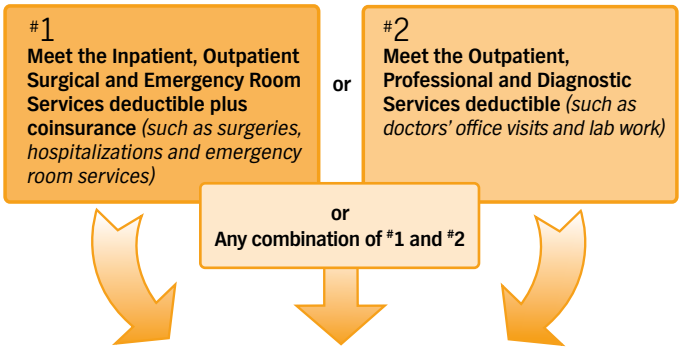
- This plan features two deductibles that work together to help you meet your total out-of-pocket maximum.
- Deductibles for Network and Non-Network covered services are the same dollar amount and accumulate separately. The same is true for Out-of-Pocket Maximums.

How ClearProtection Works

ClearProtection has two deductibles:

1. **INPATIENT, OUTPATIENT SURGICAL AND EMERGENCY ROOM SERVICES**
   This is the lower of the two deductibles to help you access benefits faster for these higher-cost services.
2. **OUTPATIENT, PROFESSIONAL AND DIAGNOSTIC SERVICES**
   This deductible is equal to your out-of-pocket maximum. So even if you only use outpatient services, once you meet this deductible, you will have also met your out-of-pocket maximum.

These two deductibles work together to help you reach your total out-of-pocket maximum. Depending on your health care needs, you can satisfy your total out-of-pocket maximum in any of the following ways:



The Total Out-Of-Pocket Maximum Equals:

$4,500 (for $1,000 deductible plan)
$6,800 (for $3,300 deductible plan)
$8,500 (for $5,000 deductible plan)

Once this amount is satisfied, the plan pays 100% of the costs for most network covered services.

Note: Deductibles and Out-of-Pocket Maximums are based on a calendar year (January 1 - December 31).

Benefits	ClearProtection℠			
Calendar Year Deductible	Deductibles for Network and Non-Network covered services are the same dollar amount and accumulate separately.			
Individual	$1,000 or $4,500	$3,300 or $6,800	$5,000 or $8,500	For Inpatient, Outpatient Surgical and Emergency Room Services or For Outpatient, Professional and Diagnostic Services
Family	$2,000 or $9,000	$6,600 or $13,600	$10,000 or $17,000	For Inpatient, Outpatient Surgical and Emergency Room Services or For Outpatient, Professional and Diagnostic Services
Network Coinsurance Options	30% 0%	30% 0%	30% 0%	For Inpatient, Outpatient Surgical and Emergency Room Services or For Outpatient, Professional and Diagnostic Services
Calendar Year Out-of-Pocket Maximum	**ALL COVERED SERVICES, IN ANY COMBINATION, APPLY TOWARD YOUR OUT-OF-POCKET MAXIMUM BELOW This is the maximum you'll pay for most network covered services each calendar year; then the plan pays 100%. Out-of-Pocket Maximums for Network and Non-Network covered services are the same dollar amount and accumulate separately.**			
Individual	$4,500	$6,800	$8,500	(these amounts include the deductibles)
Family	$9,000	$13,600	$17,000	(these amounts include the deductibles)
How family deductibles and family out-of-pocket maximums work	Once one family member reaches their individual deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined.			
Plan Lifetime Maximum	None			
Covered Services	**Your Share of Costs** (after deductible, if applicable)			
Doctors' Office Visits	**NETWORK:** **First 2 Office Visits** (per member): **$40 Copay**, deductible waived **Additional Office Visits:** **100% of negotiated fee**; then **0% Coinsurance** after out-of-pocket maximum is met **NON-NETWORK:** **100% Coinsurance**; then **0% Coinsurance** after out-of-pocket maximum is met			
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK:** **Inpatient: 30% Coinsurance** **Outpatient: 100% of negotiated fee**; then **0% Coinsurance** after out-of-pocket maximum is met **NON-NETWORK:** **Inpatient: 50% Coinsurance** **Outpatient: 100% Coinsurance**; then **0% Coinsurance** after out-of-pocket maximum is met			
Inpatient Services (overnight hospital/facility stays)	**NETWORK:** **30% Coinsurance** **NON-NETWORK:** **50% Coinsurance after Deductible**, then **0% Coinsurance** after out-of-pocket maximum is met			
Outpatient Services (without overnight hospital/facility stays)	**NETWORK:** **Surgery: 30% Coinsurance** **Other Services: 100% of negotiated fee**; then **0% Coinsurance** after out-of-pocket maximum is met **NON-NETWORK:** **100% Coinsurance after Deductible**, then **0% Coinsurance** after out-of-pocket maximum is met			
Emergency Room Services	**NETWORK:** **30% Coinsurance** PLUS $100 Emergency Room Copay (Copay waived if admitted) **NON-NETWORK:** **30% Coinsurance** PLUS $100 Emergency Room Copay (Copay waived if admitted)			
Preventive Care Services	Includes all nationally recommended preventive services including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more. **NETWORK:** **0% Coinsurance, not subject to deductible** **NON-NETWORK:** Nationally recommended preventive services: **$40 Copay** per office visit, **0% Coinsurance, not subject to deductible** Non-mandated preventive services: Not covered			
Maternity	**NETWORK:** **Inpatient: 30% Coinsurance** **Outpatient: 100% of negotiated fee**; then **0% Coinsurance** after out-of-pocket maximum is met **NON-NETWORK:** **Inpatient: 50% Coinsurance** **Outpatient: 100% Coinsurance**; then **0% Coinsurance** after out-of-pocket maximum is met			
Optional Coverage (at additional cost)	Dental, Life			
Prescription Drug Coverage	**ClearProtection**			
Retail Drugs (and Mail Order Drugs when available)	**NETWORK:** Tier 1 (Generic drugs): $15 Copay $7,500 annual Prescription Drug deductible per member applies before the following: · Tier 2 (Formulary Brand name drugs): $40 Copay · Tier 3 (Non-Formulary Brand name drugs): $60 Copay · Specialty: 25% Coinsurance up to a $2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), network only and in addition to $7,500 annual deductible. NON-Network: Not Covered			
Optional Drug Coverage (when available)	Not Available			
Other Covered Benefits include but are not limited to:	Ambulance, Home Health Care, Physical/Occupational Therapy (Visit limitations may apply for some of these benefits.)			
IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Certificate. In the event of a conflict between the Certificate and this Benefit Guide, the terms of the Certificate will prevail.	Notes: - Discounted network rates apply for network covered services. - For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount. - Copays/Coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the Certificate.			

CoreShare℠ Plus Is this the right plan for you?

CoreShare Plus Plan Highlights

This plan can be ideal for individuals who want affordable protection against significant medical expenses.

Features:

- A simple plan design with some of our lowest monthly rates.
- Higher percentage of member cost-sharing in exchange for lower premiums.
- Once the deductible is met, we'll share 50% of the costs at our negotiated rates up to $3,500, then we'll cover the rest for covered services
- Preventive care benefits help focus on keeping you healthy.
- Coverage for prescription drugs.

You should know:

- This plan has its own Drug Formulary.

Why CoreShare Plus makes sense

If you're looking for a simple plan design with some of our lowest rates, CoreShare Plus could be the plan that's right for you. CoreShare Plus offers a range of deductibles (from $750 – $7,500) and higher cost-sharing helps lower your monthly premiums.

Prescription Drug Coverage

The cost of prescription drugs can be staggering so CoreShare Plus includes prescription drug coverage to help you manage those costs.

- **Drug Formulary:** This is a special list of prescription drugs the CoreShare plan covers. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes from the Plan Formulary.
- **Tier 1:** These drugs have the lowest copay and include low-cost or preferred medications. This tier includes lower cost generic and brand-name drugs.
- **Tier 2:** These drugs have a higher copay than those in Tier 1 and include preferred medications that are generally moderate in cost. They include higher cost generic and brand-name drugs.
- **Specialty:** These are typically high-cost, scientifically engineered drugs and are paid at a coinsurance level instead of copay.

If you have questions or want more details about your options, call your Anthem Agent.

Benefits	CoreShare℠ Plus					
Calendar Year Deductible	**Your Choices**					
Individual NETWORK:	$750	$1,500	$2,500	$3,500	$5,000	$7,500
NON-NETWORK:	$750	$1,500	$2,500	$3,500	$5,000	$7,500
Family NETWORK:	$1,500	$3,000	$5,000	$7,000	$10,000	$15,000
NON-NETWORK:	$1,500	$3,000	$5,000	$7,000	$10,000	$15,000
Network Coinsurance Options	50%	50%	50%	50%	50%	50%
Calendar Year Out-of-Pocket Maximum	**Add Your Chosen Deductible to the Amount Below**					
Individual NETWORK:	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500
NON-NETWORK:	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500
Family NETWORK:	$7,000	$7,000	$7,000	$7,000	$7,000	$7,000
NON-NETWORK:	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000
How family deductibles and family out-of-pocket maximums work	Once one family member reaches their individual deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined. (See footnote below regarding separate facility copay for $750, $1,500 and $2,500 deductible plans)					
Plan Lifetime Maximum	None					
Covered Services	**Your Share of Costs** (after deductible, if applicable)					
Doctors' Office Visits	**NETWORK:** **50% Coinsurance** **NON-NETWORK:** **70% Coinsurance**					
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK:** **50% Coinsurance** **NON-NETWORK:** **70% Coinsurance**					
Inpatient Services (overnight hospital/facility stays)	**NETWORK:** **50% Coinsurance** PLUS **$500 Facility Copay**[1] per day up to the first 3 days (with $750, $1,500, $2,500) **50% Coinsurance** (with $3,500, $5,000, $7,500) **NON-NETWORK:** **70% Coinsurance** PLUS **$500 Facility Copay**[1] per day up to the first 3 days (with $750, $1,500, $2,500) **70% Coinsurance** (with $3,500, $5,000, $7,500)					
Outpatient Services (without overnight hospital/facility stays)	**NETWORK:** **50% Coinsurance** PLUS **$200 Facility Copay**[1] per admission (with $750, $1,500, $2,500) **50% Coinsurance** (with $3,500, $5,000, $7,500) **NON-NETWORK:** **70% Coinsurance** PLUS **$200 Facility Copay**[1] per admission (with $750, $1,500, $2,500) **70% Coinsurance** (with $3,500, $5,000, $7,500)					
Emergency Room Services	**NETWORK and NON-NETWORK:** **50% Coinsurance**					
Preventive Care Services	Includes all nationally recommended preventive services including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more. **NETWORK:** **0% Coinsurance, not subject to deductible** **NON-NETWORK:** Nationally recommended preventive services: **0% Coinsurance, not subject to deductible** Non-mandated preventive services: Not covered					
Maternity	**NETWORK:** **50% Coinsurance** **NON-NETWORK:** **70% Coinsurance**					
Optional Coverage (when available)	Dental, Life					
Prescription Drug Coverage	**CoreShare Plus**					
Retail and Mail Order Drugs on the Plan Formulary[2]	**NETWORK:** **Tier 1 (Generic Drugs):** **$15 Copay** $2,000 annual deductible per member applies before the following: · **Tier 2 (Higher cost Generic and Brand-name drugs):** **$35 Copay** · **Specialty:** **25% Coinsurance** up to a $2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), network only and in addition to $2,000 annual deductible. Non-formulary drugs: Not covered, discounts apply **NON-NETWORK:** Not covered					
Other Covered Benefits include but are not limited to:	Ambulance, Chiropractic Services, Home Health Care, Severe Mental Health, Physical/Occupational Therapy, Urgent Care (Visit limitations may apply for some of these benefits.)					

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Certificate. In the event of a conflict between this Benefit Guide and either the Certificate, the Certificate will prevail.

[1] Facility Copay only applies to $750, $1,500 and $2,500 deductible plans. Facility Copay **does not** accumulate toward the deductible or out-of-pocket maximum. Facility Copay is still required even if out-of-pocket maximum has been met. Balance of covered charges subject to deductible and coinsurance. No additional Facility Copay if readmitted to the same facility within 72 hours of the initial admission.

[2] CoreShare has its own Plan Formulary.

Notes:
- Discounted network rates apply for network covered services.
- Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate toward each other.
- For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount.
- Copays/Coinsurance to in-network and out-of-network providers apply to annual out-of-pocket maximum except where specifically noted in the Certificate.

Dental Coverage

Our Anthem Blue Dental PPO plan includes coverage for the basics, plus certain services like crowns, root canals and dentures. If you need a dental plan that offers important preventive services and a broad range of benefits, this could be the right plan for you.

Save money by using our dental network

We have nearly 2,000 participating dental PPO dentist locations in Colorado to choose from. While our dental PPO plan allows you to go to *any* dentist, you may save the most money when you choose one of the dentists in our PPO provider network. Even better, when you visit a network dentist, there is no deductible or member coinsurance for covered diagnostic or preventive services. For basic and major services, the calendar-year deductible is $50 per person (up to three deductibles per family) and must be satisfied before we will pay any benefits.

Diagnostic and Preventive Care

Coverage for routine check-ups, X-rays and cleanings begins the day your policy is effective.

Diagnostic and Preventive Care		
Procedure	**Plan Pays**	
	Network	**Non-Network**
Periodic oral exams, routine cleanings and X-rays *(cleanings limited to two per member per year)*	**100%**	**Fee Schedule***

Basic Dental Care

Coverage for basic dental care begins after six months of continuous coverage.

Basic Dental		
Procedure	**Plan Pays**	
	Network	**Non-Network**
Fillings	**80%**	**Fee Schedule***

Major Dental Care

Coverage for major dental care begins after 12 months of continuous coverage.

Major Dental		
Procedure	**Plan Pays**	
	Network	**Non-Network**
Extractions, root canals, crowns, dentures	**50%**	**Fee Schedule***

*For more details and a copy of our non-network fee schedule, please contact your Anthem agent.

Calendar Year Maximum Benefit

During each calendar year, the Anthem Blue Dental PPO plan provides up to $1,000 of benefits for each enrolled member.

There are currently no Anthem Blue Dental PPO-contracted dentists available in Archuleta, Baca, Bent, Chaffee, Cheyenne, Crowley, Custer, Dolores, Eagle, Elbert, Gilpin, Grand, Gunnison, Hinsdale, Jackson, Kiowa, Mineral, Moffat, Ouray, Phillips, Pitkin, Rio Blanco, Saguache, San Juan, San Miguel, Sedgwick, Washington and Yuma counties.

Non-network providers will bill members for amounts over what the member's plan pays, up to their usual charge.

The procedures in this brochure are a sample of covered services available to a member. Members who need assistance in determining the maximum payable amount to a non-network dentist may call us at the number on their ID card.

Term Life Insurance

Losing a loved one is painful enough without having to worry about finances. Give your family extra support with term life insurance from Anthem Life Insurance Company.

If you're accepted for coverage on one of our health care plans, you'll automatically be approved for our term life insurance. Plus, there are no medical exams or additional enrollment forms to worry about. It's that simple.

Term life monthly rates

Age	$15,000 Benefit	$25,000 Benefit	$50,000 Benefit	$75,000 Benefit	$100,000 Benefit
1-18	$1.50	$2.50	N/A	N/A	N/A
19-29	$2.80	$4.65	$9.30	$11.25	$13.00
30-39	$3.25	$5.40	$10.80	$13.50	$16.00
40-49	$7.50	$12.50	$25.00	$33.75	$42.00
50-59	$20.90	$34.80	$69.60	$97.50	$125.00
60-64	$29.40	$49.00	$98.00	$142.50	$185.00

Up to $100,000 in life insurance with no medical exams and no blood work required. Just check a box on your application and indicate your beneficiary. It's that simple.

Additional Information

"No Obligation" review period

After you enroll in a plan offered by Anthem, you will receive a Certificate that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You will have 30 full days to examine your plan's features. During that time, if you are not fully satisfied, you may decline coverage by returning your Certificate along with a letter notifying us that you wish to discontinue coverage. You'll receive a full refund of any premium, less any claims we've paid on your behalf. Certificates are available for you to examine prior to enrolling. Ask your agent or Anthem.

Save time with automatic premium payment

Hate writing checks? After your initial payment, our Electronic Fund Transfer (EFT) program will automatically withdraw funds from your bank account each month to pay for your health care plan premium. You'll not only save on postage, you won't have to worry about a lapse in coverage because you forgot to mail in your payment. To sign up, just fill out the billing section of the enrollment application.

Ready to choose a plan?

- After reviewing all the materials included with this brochure, contact your Anthem agent.
- Ask questions. If you aren't sure about how a plan works or have additional questions, your agent will help you.
- Fill out an application. The quickest and easiest way to complete an application is online and your agent can assist you. Or your agent can provide you with instructions for mailing or faxing your application.

If you have questions or want more details about your options, call your Anthem agent today!

Anthem

Health. **Join In.**

Individual health coverage. Your plans. Your choices.

Make sure you have all the facts

This brochure is only one piece of your plan information. Please make sure you have all the facts about the benefits offered by the plan(s) described — including what's covered, and what isn't. For additional information about exclusions, limitations, and terms of this coverage, please see the enclosed Coverage Details. This document should be included with your information kit, or if you have printed this from your computer, it should be at the end of this document. If you don't have this document, be sure to contact your Anthem agent.

This brochure is intended as a brief summary of benefits and services; it is not your Certificate. If there is any difference between this brochure and your Certificate, the provisions of the Certificate will prevail. Benefits and premiums are subject to change.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Ready to enroll?

Call your Anthem agent today!

Colorado Coverage Details

Things you need to know before you buy...

Anthem Health. **Join In.**

CoreShare Plus,[SM] SmartSense Plus,® Lumenos® HSA Plus, Premier, ClearProtection

Before choosing a health care plan, please review the following information, along with the other materials enclosed.

To Enroll, You And Your Dependents Must Be:

- At least 19 years of age (not to exceed 64 3/4 years of age) to be eligible as the main subscriber. Child dependents under the age of 19 must apply and be enrolled with at least one parent or legal guardian (age 19 years or older)
- A permanent legal resident of Colorado

Medical Underwriting Requirement

We believe the cost of our plans should be consistent with your expected health care needs and risk factors. That's why Anthem offers various levels of coverage. To determine individual medical risk factors, all enrollments are subject to medical underwriting. Depending on the results of the underwriting review, a number of things may happen:

- You may be offered coverage at the standard premium rate, or
- You may be offered the plan you selected at a higher rate, or
- You may not qualify for the plan(s) listed in this brochure, or
- You may be offered an alternate plan

If you have a significant medical condition and don't qualify for the plan you've chosen from this brochure or if you have discontinued group coverage, please contact your Anthem representative for information regarding other Individual coverage options.

Waiting Periods

For applicants age nineteen (19) and older there is a 12-month waiting period for coverage of any health condition, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received within 12 months preceding the coverage effective date. If you apply for coverage within 90 days of terminating your membership with another 'creditable' health care benefits plan, you may use your prior coverage for credit toward the 12-month waiting period. Anthem will credit the time you were enrolled in the previous plan. The pre-existing condition limitation does not apply to applicants under age nineteen (19). Consult with your Anthem agent or representative if you have a question about the underwriting process.

Guaranteed Renewability Of All Individual Health Policies

Anthem will not cancel or refuse to renew any Individual policy, except for the following reasons:

- Non-payment of premium
- Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by the insured
- Anthem elects to discontinue offering all Individual policies
- The state insurance commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders
- The state insurance commissioner finds that the product form is obsolete and is being replaced with comparable coverage

Network Access Plan

Anthem strives to provide a provider network that adequately addresses members' health care needs. The network access plan describes Anthem's provider network standards for network adequacy in service, access and availability, as well as assessment procedures for determining if the network continues to meet member needs. The network access plan is available on request for in-person review at our customer service department.

Colorado Health Plan Description Form

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 business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, on oral or written request, within three business days to any person who is interested in coverage under, or who is covered by, a health care benefits plan of the carrier. If you would like a copy of the state mandated Colorado Health Plan Description Form, which provides information on health plan benefits, provider contract arrangements and other information, please contact your Anthem agent. For complete details about benefits, procedures, limitations and exclusions, please refer to the Health Plan Description Form and Certificate. In the event of a conflict between anything printed in this brochure and the Certificate, the terms of the Certificate will prevail.

Terms Of Coverage

Coverage remains in force as long as you pay the required premiums on time and for as long as you remain eligible for membership. Coverage will cease if you become ineligible due to:

- Residency requirements and/or
- Duplicate Individual coverage with Anthem

We may change rates with 30-day advance written notice. We may change coverage or benefits with 90-day advance written notice. Anthem does not change coverage or rates unless the change applies to all covered persons of the same class.

Access To The Medical Information Bureau (MIB)

Information regarding your insurability will be treated as confidential. Anthem or its reinsurers may, however, make a brief report thereon to the MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734.

Information for consumers about MIB may be obtained on its website at www.mib.com.

Anthem, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prospective Review / Pre-Admission Review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for prospective review may include but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g. without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed healthcare professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

Exclusions and Limitations

The following information will help you understand what your health care plan does not include before you enroll. This is an overview only. For a complete list of exclusions and limitations, you can request a copy of the plan's Health Plan Description Form and Certificate.

CoreShare Plus, SmartSense Plus, Premier and ClearProtection Plans Do Not Cover:

- Acupuncture
- Conditions covered by workers' compensation or similar law
- Experimental or investigative services
- Services provided by a local, state or federal government
- Services or supplies not specifically listed as covered in the Certificate
- Services received before your plan effective date or after coverage ends, except as stated in your Certificate
- Services you wouldn't have to pay for without insurance
- Services from relatives
- Any services received by Medicare benefits without payment of additional premium
- Services or supplies that are not medically necessary
- Routine exams and immunizations related to sports, insurance, condition of employment, for licensing, school, church or camp or routine care received in the emergency room
- Sex change operations
- Cosmetic surgery
- Services primarily for weight reduction except medically necessary treatment for morbid obesity
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Certificate

- Hearing aids, except as specifically stated in the Certificate
- Infertility services
- Hair loss, even if there is a physician prescription and a medical reason for the hair loss
- Private duty nursing
- Eyeglasses or contact lenses
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Certificate
- Services received for mental and nervous disorders and substance abuse, except as specifically stated in the Certificate
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Certificate
- Services or supplies related to a pre-existing condition, for applicants age nineteen and older
- Outdoor treatment programs
- Telephone, Internet or facsimile machine consultations
- Educational services except as specifically provided or arranged by Anthem
- Nutritional counseling, food or dietary supplements except as specifically stated in the Certificate
- Personal comfort items
- Custodial care
- Certain genetic testing
- Outpatient speech therapy, except as specifically stated in the Certificate

Lumenos HSA Plus Does Not Cover:

- All services related to artificial conception, except as provided in the member's Certificate
- Auto accident injuries, except as provided in the member's Certificate
- Breast reduction surgery or services related to breast reduction surgery, unless the surgery is performed as a result of breast cancer
- Services received before the member's plan effective date
- Services received after the member's coverage ends, except as provided in the member's Certificate
- Complications resulting from non-covered services and supplies
- Convalescent care from a period of illness, injury or surgery unless normally received for a specific condition, as determined by Anthem Blue Cross and Blue Shield's medical policy
- Cosmetic services
- Court-ordered services, unless those services would otherwise be covered under the member's Certificate
- Custodial Care
- Dental services, except as provided in the member's Certificate
- Experimental or investigational services
- Genetic testing/counseling
- Government operated facility, including veterans administration facility
- Hair loss, even if there is a physician prescription and a medical reason for the hair loss
- Hypnosis, whether for medical or anesthesia purposes
- Services or supplies for illness or injuries resulting from the member's conduct that may be deemed a crime or other violation of law
- Intractable pain or chronic pain
- Learning deficiency and/or behavioral problem therapies, except as provided in the member's Certificate
- Maintenance therapy
- Charges for the member's failure to keep scheduled appointments
- Neuropsychiatric testing, unless allowed by Anthem's medical policy
- Over-the-counter products
- Services or supplies that are not medically necessary
- For ages 19 and older, services related to a pre-existing condition as defined in the member's Certificate
- Private duty nursing
- Private room expenses, except as provided in the member's Certificate
- Professional or courtesy discounts the member receives from a provider for services and supplies
- Radiology services such as Ultrafast CT scan and peripheral bone density testing, except as provided in the member's Certificate
- Charges for the preparation of medical reports, itemized bills or charges for duplication of medical records from a provider when requested by the member
- Services for self-inflicted injuries, except where the law prohibits such an exclusion
- Services the member wouldn't have to pay for without insurance (free services)
- Sex change operations
- Services related to alcohol or drug abuse except as provided in the member's Certificate
- Travel expenses, except as provided in the member's Certificate
- Vision care
- Services or supplies necessary to treat disease or injury resulting from war, civil war, insurrection, rebellion or revolution
- Services primarily for weight reduction, except medically necessary treatment for morbid obesity
- Work-related accidents or illnesses covered by worker's compensation

SmartSense Plus, ClearProtection, Premier, and Lumenos HSA Plus plans do not cover autism.

Dental Benefits Which Are Not Covered By Anthem Dental

The following information will help you understand what your dental care plan does not include before you enroll. This is an overview only. For a complete list of exclusions and limitations, you can request a copy of the Dental Plan Certificate.

Limitations

This is a partial list of plan limitations. Please see the Individual Dental Plan Contract for a complete list.

- Oral Evaluations: Limited to two per calendar year
- Routine Cleaning or Periodontal Cleaning: Limited to two treatments per calendar year
- Fluoride: Fluoride treatment limited to two per calendar year for children up to age 19

- X-rays: Limited to one set of full-mouth X-rays or its equivalent in a five-year period. Periapical X-rays are limited to four films per year
- Bitewing X-rays: Limited to one set of up to four films once per calendar year
- Sealants, for unrestored permanent 1st and 2nd molars. Limited to one application per tooth and one replacement per tooth if replacement is performed at least 36 months after initial application. Covered only for dependent children up to the age of 16
- Space Maintainers. Limited to once per quadrant per lifetime for children up to the age of 16. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes initial prosthesis only and all adjustment within six months of placement
- Restorations: Limited to once per surface per tooth every 24 months
- Periodontal Scaling: Limited to once per quadrant every 24 months
- Periodontal Surgery: Limited to one time per quadrant in a 36-month period
- Root Canal Therapy: Limited to one treatment per tooth for initial treatment and one retreatment per tooth per lifetime — for permanent teeth only
- Stainless Steel Crowns: Limited to baby teeth only. Once per tooth in any five years
- Crowns: Limited to once per tooth in any seven years
- Removable, Partial and Complete Dentures: Limited to once in seven years. Benefits are payable for either complete or immediate dentures, but not both
- General Anesthesia: Covered only when used in conjunction with covered oral surgical procedures

Exclusions

This is a partial listing of plan exclusions. Please see the Individual Dental Plan Contract for a complete list.

- Prescribed drugs, pre-medication or analgesia including charges for nitrous oxide or any similar local anesthetic when not included as part of a covered procedure
- Occlusal guards
- Bleaching of non-vital discolored teeth
- Crown buildups on the same tooth as an amalgam or composite restoration that was done within the same calendar year
- Procedures to alter, restore or maintain occlusion, change vertical dimension, and replace or stabilize tooth structure lost by attrition, abrasion, erosion or bruxism
- Harmful habit appliances
- Services related to diagnosis or treatment related to the temporomandibular joint (TMJ)
- Dental implants and all adjunctive services performed in conjunction with the placement or removal of implants including but not limited to surgery, cleanings, maintenance and prosthetics placed on implants
- Infection control procedures, if billed separately
- Precision attachments
- Prefabricated resin crown or stainless steel crown with resin window
- Pulpotomy on permanent teeth
- Replacement of a prosthodontic appliance (fixed or removable) more often than once in any seven-year period, whether under this Contract or under any prior dental coverage
- Root canal therapy on baby teeth
- Sealants on restored teeth (occlusal surface)
- Temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.)
- Services or supplies not specifically listed in the covered services section of the Individual Dental Plan Contract

This is not a contract of insurance and only your Application, Certificate of Coverage and your Health Plan Description Form constitute legally binding documents. Please refer to the applicable Certificate/Health Plan Description Form which sets forth, in more detail, the benefits, limitations and exclusions. If there are any conflicts between the terms of the Certificate/Health Plan Description Form and the information outlined above, the terms of the Certificate/Health Plan Description Form will prevail.

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Selecting health coverage is an important decision.

To assist you, we are also providing you with the Brochure, Health Plan Description Form and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem agent to request them.

The Certificate/Health Plan Description Form is also available for you to examine before enrolling. Ask your Anthem agent or Anthem.

Anthem
Health. Join In.

Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
Colorado Individual ClearProtection 1,000; 3,300; 5,000 Plan
Effective January 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] **Inpatient Surgical/Hospital Deductible**	**Not combined for In-Network and Out-of-Network** Applicable only to the following services: ○ All inpatient services ○ Ambulatory Surgery Center Services ○ Emergency Room Visits ○ Home Health Care ○ Skilled Nursing Care ○ Hospice Services ○ Ambulance Services	
a) Individual[2b]	$1,000; 3,300; 5,000 per individual During each Year, each member is responsible for all Surgical/Hospital expenses incurred up to the Surgical/Hospital Deductible amount. Once you have satisfied your Surgical/Hospital Deductible, no further Surgical/Hospital Deductible will be required for the remainder of that Year.	$ 1,000; 3,300; 5,000 per individual During each Year, each member is responsible for all Surgical/Hospital expenses incurred up to the Surgical/Hospital Deductible amount. Once you have satisfied your Surgical/Hospital Deductible, no further Surgical/Hospital Deductible will be required for the remainder of that Year.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

	IN-NETWORK	OUT-OF-NETWORK
b) Family[2c]	$2,000; 6,600; 10,000 maximum per family During each year, each member is responsible for all Surgical/Hospital expenses incurred up to the Surgical/Hospital deductible amount. Once you have satisfied your In-Network Surgical/Hospital deductible, no further Surgical/Hospital deductible will be required for the remainder of that year. Once the total of allowable charges applying to the Surgical/Hospital Deductible for two (2) or more Insureds equal the Surgical/Hospital Deductible Family Maximum, no further Surgical/Hospital Deductible will be required for all enrolled Insureds for the remainder of that Year. No one Insured can contribute more than the individual deductible amount to the family deductible amount.	$ 2,000; 6,600; 10,000 maximum per family During each year, each member is responsible for all Surgical/Hospital expenses incurred up to the Surgical/Hospital deductible amount. Once you have satisfied your Out-of-Network Surgical/Hospital deductible, no further Surgical/Hospital deductible will be required for the remainder of that year. Once the total of allowable charges applying to the Surgical/Hospital Deductible for two (2) or more Insureds equal the Surgical/Hospital Deductible Family Maximum, no further Surgical/Hospital Deductible will be required for all enrolled Insureds for the remainder of that Year. No one Insured can contribute more than the individual deductible amount to the family deductible amount. For Non-Participating providers, the member must pay the difference between Anthem's maximum allowed amount and the non-participating provider's billed charges, unless noted otherwise. Charges in excess of the maximum allowed amount do not count towards satisfying the Inpatient Surgical/Medical Deductible. Please see the section of your certificate entitled About Your Health Coverage for details about cost sharing requirements.
Outpatient Professional Services Deductible	**Not combined for In-Network and Out-of-Network** Applicable only to the following services: ○ Professional Services ○ Outpatient Services ○ Physical Therapy ○ Occupational Therapy ○ Speech Therapy	
a) Individual[2b]	$4,500; 6,800; 8,500 per Individual During each Year, each member is responsible for all Outpatient Professional expenses incurred up to the Outpatient Professional Services Deductible amount. Once you have satisfied your In Network and/or Out-of-Network Provider Outpatient Professional Services Deductible, no further Outpatient Professional Services Deductible will be required for the remainder of that Year.	$4,500; 6,800; 8,500 per Individual During each Year, each member is responsible for all Outpatient Professional expenses incurred up to the Outpatient Professional Services Deductible amount. Once you have satisfied your In Network and/or Out-of-Network Provider Outpatient Professional Services Deductible, no further Outpatient Professional Services Deductible will be required for the remainder of that Year.

	IN-NETWORK	OUT-OF-NETWORK
b) Family[2c]	$9,000; 13,600; 17,000 maximum per family Once the total of allowable charges applying to the Outpatient Professional Services Deductible for two (2) or more members equal the Outpatient Professional Services Deductible Family Maximum, no further Outpatient Professional Services Deductible will be required for all enrolled members for the remainder of that Year. No one member can contribute more than the individual deductible amount to the family deductible amount	$9,000; 13,600; 17,000 maximum per family Once the total of allowable charges applying to the Outpatient Professional Services Deductible for two (2) or more members equal the Outpatient Professional Services Deductible Family Maximum, no further Outpatient Professional Services Deductible will be required for all enrolled members for the remainder of that Year. No one member can contribute more than the individual deductible amount to the family deductible amount. For Non-Participating providers, the member must pay the difference between Anthem's maximum allowed amount and the non-participating provider's billed charges, unless noted otherwise. Charges in excess of the maximum allowed amount do not count towards satisfying the Outpatient Professional Services Deductible. Please see the section of your certificate entitled About Your Health Coverage for details about cost sharing requirements.
	Note: The first two (2) office visits from In-Network Providers are covered at a $40 copay per member, per calendar year regardless of the type of provider seen. The Outpatient Professional Services Deductible is waived, but the $40 office visit copayment will not be applied towards the In-network Out-of-Pocket Annual maximum. Copayment amounts do not apply to either the Inpatient Surgical/Hospital Deductible or the Outpatient Professional Services Deductible.	

	IN-NETWORK	OUT-OF-NETWORK
5. OUT-OF-POCKET ANNUAL MAXIMUM	The Out-of-Pocket Annual Maximum includes the deductibles, but is **not** combined for In and Out-of-Network.	
a) Individual[3]	$4,500; 6,800; 8,500 per individual, includes deductible and coinsurance.	$4,500; 6,800; 8,500 per individual, includes deductible and coinsurance.
b) Family	$9,000; 13,600; 17,000 per family, includes deductible and coinsurance. Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual out-of-pocket annual maximum, combine to equal the family out-of-pocket annual maximum, no member will be required to pay Surgical/Hospital Deductible amounts, Yearly Outpatient Professional Services Deductible amount or Copayment/Coinsurance amounts, except as otherwise required by this policy for the remainder of that year. However, no one person can contribute more than their individual out-of-pocket annual maximum amount to the family out-of-pocket annual maximum.	$9,000; 13,600; 17,000 per family, includes deductible and coinsurance. Under a family membership (two (2) or more members enrolled), once two (2) or more members' allowable charges that applied to their individual out-of-pocket annual maximum, combine to equal the family out-of-pocket annual maximum, member will be required to pay Surgical/Hospital Deductible amounts, Yearly Outpatient Professional Services Deductible amount or Copayment/Coinsurance amounts, except as otherwise required by this policy for the remainder of that year, **except** for charges in excess of the maximum allowed amount and where specifically noted in the certificate. However, no one person can contribute more than their individual out-of-pocket annual maximum amount to the family out-of-pocket annual maximum. A member will always be responsible for the difference between billed charges and the maximum allowed amount for non-participating providers, even after reaching the Out-of-Pocket Annual Maximum for Out-of-Network services. Charges in excess of the maximum allowed amount do not count towards satisfying the Out-of-Pocket Annual Maximum.
c) Is the deductible included in the out-of-pocket maximum?	Yes	Yes
	Copayments amounts do not apply to the Out-of-Pocket Annual Maximum. Prescription drug expenses do not apply towards this Out of Pocket maximum and will accumulate towards separate maximums as indicated in # 11 Prescription Drugs.	
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.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes

	IN-NETWORK	OUT-OF-NETWORK
8. MEDICAL OFFICE VISITS[4] Subject to the Outpatient Professional Services Deductible	\$40 copayment per office visit for the first two (2) office visits in a calendar year.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.
a) Primary Care Providers	After the first two (2) office visits in a calendar year have been used, the member pays 100% of the allowed amount until the Outpatient Professional Services Deductible has been satisfied, then 0% coinsurance	
b) Specialists	\$40 copayment per office visit for the first two (2) office visits in calendar year. After the first two (2) office visits in a calendar year have been used, the member pays 100% of the allowed amount until the Outpatient Professional Services Deductible has been satisfied, then 0% coinsurance	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.
	The first two (2) office visits from In-Network Providers are covered at a \$40 copay per member, per calendar year regardless of the type of provider seen. The total number of visits covered at the \$40 copay is combined for all In-Network Providers. No Outpatient Professional Services Deductible is required for the first two (2) office visits from In-Network Providers. Services covered as part of an office visit include: ∘ History (gathering of information on an illness or injury) ∘ Examination ∘ Medical decision making (the physician's actual diagnosis and treatment plan) All other covered professional services, including, but not limited to laboratory, X-ray, radiology and pathology services are subject to applicable deductible, coinsurance, or cost sharing. Please see the Professional Services section of the certificate for a full description of covered professional services. After the first two (2) In-Network physician office visits have been used, charges for additional physician office visits will be subject to the Outpatient Professional Services Deductible and Out-of-Pocket Annual Maximum. Copayment amounts do not apply to the deductible or the out of pocket maximum.	

	IN-NETWORK	OUT-OF-NETWORK
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.	$40 copay, not subject to the Outpatient Professional Services Deductible 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. All other preventive care services (not mandated by Colorado law) are not covered.

	IN-NETWORK	OUT-OF-NETWORK
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.	$40 copay, not subject to the Outpatient Professional Services Deductible for: Routine cytological screening (pap test), mammography benefit in accordance to 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. All other preventive care services (not mandated by Colorado law) are not covered.
	Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services. Copayment amounts paid to out of network providers do not apply to the Inpatient Surgical/Hospital Deductible, the Outpatient Professional Services Deductible or the Out of Pocket annual maximum.	
10. MATERNITY **Outpatient Services are subject to the Outpatient Professional Services Deductible** **Inpatient Services are subject to the Inpatient Surgical/Hospital Deductible**		
a) Prenatal care **(outpaitient services)**	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied 50% coinsurance plus all charges in excess of the maximum allowed amount.
(inpatient services)	After the Inpatient Surgical/Hospital Deductible has been satisfied 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied 50% coinsurance plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
b) Delivery & inpatient well baby care[5]	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions** **a) Outpatient care**	**Retail Pharmacy:** **Tier 1 Prescription Drugs:** ○ $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: ○ $40 copayment for each prescription and/or refill for a maximum thirty (30) day supply. **Tier 3 Prescription Drugs:** After the $7500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied: ○ $60 copayment 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: ○ 25% 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

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions (continued)** **b) Prescription Mail Service**	**Mail Order:** ○ **Tier 1 Prescription Drugs:** $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: ○ $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: ○ $180 copayment for each prescription and/or refill up to a maximum ninety (90) day supply.	Not covered
	Tier 2 and Tier 3 Prescription Drug Deductible Each member must meet a Tier 2 and Tier 3 Prescription Drug Deductible amount of $7500 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 Out of Pocket Maximum** There is a $2500 Tier 3 Specialty Prescription Drug Out-of-Pocket maximum per member per calendar year when purchased from a preferred specialty pharmacy. You will not be required to pay more than $2500 per member per calendar year for prescription drugs purchased at a preferred specialty pharmacy. Once the Tier 3 Specialty Prescription Drug Out of Pocket Maximum is met, no further Coinsurance will be required for drugs purchased from a preferred special pharmacy for the remainder of that calendar year. Copayments for Tier 1 and Tier 2 drugs will not accumulate towards the Tier 3 Specialty Prescription Drug Out of Pocket Maximum, and will continue to be required even after the Tier 3 Specialty Prescription Drug Out of Pocket Maximum has been reached. Prescription drug expenses do not apply towards the Out of Pocket maximum for medical benefits and will accumulate towards the separate maximums indicated above. Note: Specialty drugs are only available through Anthem's specialty pharmacy benefit manager. Drugs obtained from pharmacies outside the United States will not be covered unless such drugs are prescribed in connection with Emergency	

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions (continued)**	**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 **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied 50% coinsurance plus all charges in excess of the maximum allowed amount.
13. OUTPATIENT/AMBULATORY SURGERY **Surgical Services are Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied 50% coinsurance, plus all charges in excess of the maximum allowed amount.
Non-Surgical Services are Subject to the Outpatient Professional Services Deductible	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.
14. DIAGNOSTICS **a) Laboratory & x-ray (inpatient services)** **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
(outpatient services) **Subject to the Outpatient Professional Services Deductible**	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied 0% coinsurance plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
14. DIAGNOSTICS (continued) **b) MRI, nuclear medicine, and other high-tech services (inpatient services) Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
(outpatient services) Subject to the Outpatient Professional Services Deductible	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance 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] Subject to the Inpatient Surgical/Hospital Deductible	After the Inpatient Surgical/Hospital Deductible 30% coinsurance after deductible.	After the Inpatient Surgical/Hospital Deductible 30% coinsurance after deductible.
	Emergency Room services are subject to an additional $100 Copayment per visit which will not be applied towards the Inpatient Surgical/Hospital Deductible or Out-of-Pocket Annual Maximum. The $100 emergency room copayment is waived if the visit results in an inpatient admission into a Hospital immediately following the emergency room services. Copayment amounts do not apply to the Inpatient Surgical/Hospital Deductible or the Out of Pocket Annual Maximum.	
16. AMBULANCE Subject to the Inpatient Surgical/Hospital Deductible **a) Ground**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.
b) Air	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE Subject to the Outpatient Professional Services Deductible	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Not covered.	
19. OTHER MENTAL HEALTH CARE **a) Inpatient care**	Not covered.	Not covered.
b) Outpatient care	Not covered.	Not covered.
20. ALCOHOL & SUBSTANCE ABUSE	Not covered.	Not covered.

	IN-NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY **a) Inpatient** **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
b) Outpatient Including outpatient therapy for congenital defects and birth abnormalities **Subject to the Outpatient Professional Services Deductible**	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.
	Limited to twenty-four (24) visits per calendar year for physical therapy and occupational therapy; in- and out-of-network combined. Speech therapy is limited to fifty (50) visits per member in each calendar year in- and out-of-network combined. For children, beginning when the child turns three and ceasing when the child turns six, benefits are available, limited to twenty (20) visits each for physical therapy, occupational therapy and/or speech therapy per calendar year; in- and out-of-network combined.	
22. DURABLE MEDICAL EQUIPMENT **(inpatient)** **Inpatient equipment is subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
(outpatient) **Outpatient equipment is subject to the Outpatient Professional Services Deductible**	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.
	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. Any benefit paid for prosthetic devices shall not count toward the annual durable medical equipment maximum reference above. Footwear is limited to a $400 maximum Anthem payment per calendar year, in and out-of-network combined. 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.	
23. OXYGEN **(inpatient)** **Inpatient oxygen services are subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
(outpatient) **Outpatient oxygen services are subject to the Outpatient Professional Services Deductible**	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance.	After the Outpatient Professional Services Deductible has been satisfied, 0% coinsurance plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
24. ORGAN TRANSPLANTS **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
25. HOME HEALTH CARE **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance 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. Visits are up to four (4) hours or less for each visit.	
26. HOSPICE CARE **a) Inpatient Care** **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
b) Outpatient care **Subject to the Outpatient Professional Services Deductible**	After the Outpatient Professional Services Deductible, 0% coinsurance.	After the Outpatient Professional Services Deductible, 0% 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 $1,150 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.	
27. SKILLED NURSING FACILITY CARE **Subject to the Inpatient Surgical/Hospital Deductible**	After the Inpatient Surgical/Hospital Deductible has been satisfied, 30% coinsurance.	After the Inpatient Surgical/Hospital Deductible has been satisfied, 50% coinsurance plus all charges in excess of the maximum allowed amount.
	Benefits are limited to thirty (30) days per member per year, in– and out-of-network combined for skilled nursing services, wherever they are received.	
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Not covered	Not covered
30. CHIROPRACTIC CARE	Not covered).	Not covered.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Members who desire another professional opinion may obtain a second surgical opinion. Inpatient Respiratory therapy is covered subject to the Inpatient Surgical/Hospital Deductible. Outpatient Respiratory therapy is covered subject to the Outpatient Professional Services Deductible. Respiratory therapy (inpatient and outpatient) is limited to twenty (20) visits per year, in- and out-of-network providers combined. Inpatient Chemotherapy, Hemodialysis, and Radiation Therapy are covered subject to the Inpatient Surgical Hospital Deductible. Outpatient Chemotherapy, Hemodialysis and Radiation Therapy are covered subject to the Outpatient Professional Services Deductible. 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

	IN-NETWORK	OUT-OF-NETWORK
32. 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.	
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No	
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	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.	
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review the list to see if a service or treatment you may need is excluded from the policy.	

PART D: USING THE PLAN

36. 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.
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining preauthorization.	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
39. What is the main customer service number?	(888) 231-5046	
40. 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	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance, ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form # MCOCN559A, individual	
43. Does the plan have a binding arbitration clause?	Yes	

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

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

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

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

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

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

[4] Medical office visits include physician, mid-level practitioner, and specialist visits, 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.

Anthem
Health. Join In.

Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
Colorado Individual CoreShare Plus Plan
Effective January 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]	**Individual[2b]** $750 $1,500 $2,500 $3,500 $5,000 $7,500	**Family[2c]** $1,500 $3,000 $5,000 $7,000 $10,000 $15,000	**Individual** $750 $1,500 $2,500 $3,500 $5,000 $7,500	**Family** $1,500 $3,000 $5,000 $7,000 $10,000 $15,000
5. OUT-OF-POCKET ANNUAL MAXIMUM **Includes deductible, copayments and coinsurance**	**Individual[3]** $4,250 $5,000 $6,000 $7,000 $8,500 $11,000	**Family** $8,500 $10,000 $12,000 $14,000 $17,000 $22,000	**Individual** $8,250 $9,000 $10,000 $11,000 $12,500 $15,000	**Family** $16,500 $18,000 $20,000 $22,000 $25,000 $30,000
	Prescription drug expenses do not apply towards this Out of Pocket maximum and will accumulate towards separate maximums as indicated in # 11 Prescription Drugs.			
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime limits. For benefit limits please see each applicable benefit below			

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

	IN-NETWORK	OUT-OF-NETWORK
7A. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list or current providers.	All providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Yes	Yes
8. MEDICAL OFFICE VISITS[4] **a) Primary Care Providers** For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible	70% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) Specialists For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance after deductible plus all charges in excess of the maximum allowed amount.
9. PREVENTIVE CARE (All plans) **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.	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. All other preventive services are not covered.

	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE (All plans) (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.	Deductible waived. No coinsurance required for: Routine cytological screening (pap test), mammography benefit in accordance to 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. All other preventive services are not covered.
	Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.	
10. MATERNITY **a) Prenatal care** For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) Delivery & inpatient well baby care[5] For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% 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** **(All plans)**		
a) Outpatient care	**Retail Pharmacy:** **Tier 1 Prescription Drugs:** • $15 copayment for each prescription and/or refill for a maximum thirty (30) day supply. **Tier 2 Prescription Drugs:** After the $2000 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied: • $35 copayment for each prescription and/or refill for a maximum thirty (30) day supply. **Tier 3 Pharmacy Drugs:** After the $2,000 Tier2 and Tier 3 Prescription Drug Deductible has been satisfied: • 25% coinsurance for each prescription and/or refill for a maximum thirty (30) day supply.	Not covered
b) Prescription Mail Service	**Mail Order:** • **Tier 1 Prescription Drugs:** $45.00 copayment for each prescription and/or refill up to a maximum ninety (90) day supply. **Tier 2 Prescription Drugs:** After a $2000 per member per calendar year Tier 2 and Tier 3 Prescription Drug Deductible is satisfied: • $105.00 copayment for each prescription and/or refill up to a maximum ninety (90) day supply. **Tier 3 Prescription Drugs:** After a $2000 per member per calendar year Tier 2 and Tier 3 Prescription Drug Deductible is satisfied: • 25% of negotiated fee for each prescription and/or refill up to a maximum ninety (90) day supply.	Not covered

	IN-NETWORK	OUT-OF-NETWORK
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions (continued)**	**Tier 3 Prescription Drug Out of Pocket Maximum** There is a $2500 Tier 3 Out-of-Pocket maximum per member per calendar year when purchased from a participating pharmacy. You will not be required to pay more than $2500 per member per calendar year for prescription drugs purchased at a participating pharmacy. Once the Tier 3 Prescription Drug Out of Pocket Maximum is met, no further Coinsurance will be required for drugs purchased from a participating pharmacy for the remainder of that calendar year. Copayments for Tier 1 and Tier 2 drugs will not accumulate towards the Tier 3 Prescription Drug Out of Pocket Maximum, and will continue to be required even after the Tier 3 Prescription Drug Out of Pocket Maximum has been reached. Prescription drug expenses do not apply towards the Out of Pocket maximum for medical benefits and will accumulate towards the separate maximums indicated above. Note: Specialty drugs are only available through Anthem's specialty pharmacy benefit manager. Drugs obtained from pharmacies outside the United States will not be covered unless such drugs are prescribed in connection with Emergency **These benefits apply only to prescription drugs listed on the Plan Formulary. Non-Formulary Prescription Drug are not covered.** **Note:** Charges for Non-Formulary Prescription Drugs will not be applied towards the Tier 2 and Tier 3 Prescription Drug Deductible or the Tier 3 Prescription Drug Out of Pocket Maximum. 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 For $750, $1,500, $2,500 plans:	$500 inpatient facility copayment per day up to three (3) days per admission, then 50% coinsurance after deductible.	$500 inpatient facility copayment per day up to three (3) days, then 70% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
For $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Facility copayments will not apply towards the deductible or out-of-pocket annual maximum and will still be required after out-of-pocket maximum is met.	

	IN-NETWORK	OUT-OF-NETWORK
13. OUTPATIENT/AMBULATORY SURGERY		
For $750, $1,500, $2,500 plans:	$200 outpatient surgery facility copayment per admission, then 50% coinsurance after deductible.	$200 outpatient surgery facility copayment per admission, then 70% coinsurance after deductible, plus all charges in excess of the maximum benefit allowance.
For $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	No outpatient surgery facility copayment will be required if admitted as inpatient within 72 hours of initial outpatient hospital admission. Facility copayments will not apply towards the deductible or out-of-pocket annual maximum and will still be required after out-of-pocket maximum is met.	
14. DIAGNOSTICS **a) Laboratory & x-ray** For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) MRI, nuclear medicine, and other high-tech services For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% 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] For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	50% coinsurance after deductible.
16. AMBULANCE **a) Ground** For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	50% coinsurance after deductible.
b) Air For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	50% coinsurance after deductible.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum allowed amount, after deductible.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	Coverage is no less extensive than the coverage provided for any other physical illness.	

	IN-NETWORK	OUT-OF-NETWORK
19. OTHER MENTAL HEALTH CARE **a) Inpatient care** For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum allowed amount, after deductible.
b) Outpatient care For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum allowed amount, after deductible.
	Anthem will cover other mental health care and alcohol & substance abuse benefits up to a maximum of thirty (30) days per member per calendar Year, In-Network and Out-of-Network providers combined for inpatient care. Anthem will cover other mental health care and alcohol & substance abuse benefits up to a maximum of forty-eight (48) visits per member per calendar year In-Network and Out-of-Network providers combined for outpatient care.	
20. ALCOHOL & SUBSTANCE ABUSE For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum allowed amount, after deductible.
	Anthem will cover other mental health care and alcohol & substance abuse benefits up to a maximum of thirty (30) days per member per calendar Year, In-Network and Out-of-Network providers combined for inpatient care. Anthem will cover other mental health care and alcohol & substance abuse benefits up to a maximum of forty-eight (48) visits per member per calendar year In-Network and Out-of-Network providers combined for outpatient care.	

	IN-NETWORK	OUT-OF-NETWORK
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY **a) Inpatient** For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum allowed amount, after deductible.
b) Outpatient Including outpatient therapy for congenital defects and birth abnormalities For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum allowed amount, after deductible.
	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. 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.	
22. DURABLE MEDICAL EQUIPMENT For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum allowed amount, after deductible.
	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.	
23. OXYGEN For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum allowed amount, after deductible.
24. ORGAN TRANSPLANTS For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible	70% coinsurance plus all charges in excess of the maximum allowed amount, after deductible.
24. HOME HEALTH CARE For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum allowed amount, after deductible.
	Limited to sixty (60) visits per member each calendar year, in- and out-of-network combined. Visits are up to four (4) hours or less for each visit.	

	IN-NETWORK	OUT-OF-NETWORK
26. HOSPICE CARE **a) Inpatient Care** For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum allowed amount, after deductible.
b) Outpatient care For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum allowed amount, after deductible.
	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 $1,150 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.	
27. SKILLED NURSING FACILITY CARE For $750, $1,500, $2,500, $3,500, $5,000 and $7,500 plans:	50% coinsurance after deductible.	70% coinsurance plus all charges in excess of the maximum allowed amount, after deductible.
	Benefits are limited to twenty (20) days per member per year, in- and out-of-network combined for skilled nursing services, wherever they are received.	
28. DENTAL CARE (All plans)	Not covered	Not covered
29. VISION CARE (All plans)	Not covered	Not covered
30. CHIROPRACTIC CARE (All plans)	Covered under PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY (see line 21).	Covered under PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY (see line 21).
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5) (All plans)	Members who desire another professional opinion may obtain a second surgical opinion. Respiratory therapy is limited to twenty (20) visits per year, in- and out-of-network providers combined. 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

32. 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.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	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.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review 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. 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.
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining preauthorization.	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
39. What is the main customer service number?	(888) 231-5046	
40. 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	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance, ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form # MCOCN3933A, individual	
43. Does the plan have a binding arbitration clause?	Yes	

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

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

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

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

[2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "$3000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

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

[4] Medical office visits include physician, mid-level practitioner, and specialist visits, 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.