

Open enrollment period runs
November 1, 2018 - January 15, 2019



How to choose and use your health plan

Get the answers you need
with this helpful guide



Colorado

2019 Plan Year

Individual and Family

Bronze, Silver and Catastrophic plans

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What you need to know to choose a plan that's right for you.

Your options for coverage



Medical plans: Our individual and family health insurance plans give you lots of options. You'll get preventive care, such as screenings and flu shots, for as low as \$0, with no copay from **in-network** doctors (doctors in your plan). Plus, you won't have to meet your deductible first. And you'll have the health insurance you need in case of an emergency or illness.



Dental/vision: With our health plans, you'll get pediatric essential health benefits for dental and vision. For extra coverage, Anthem offers stand-alone dental and vision insurance for you and your whole family, with great care from leading doctors. Whether it's dental or vision you're looking for, we've got a plan for you.



Term Life insurance: Anthem Life Insurance Company now offers low cost term life insurance coverage. Our Individual term life plans include two coverage options: \$25,000 and \$50,000. You can choose the coverage amount that fits your needs. Life insurance is an important decision, but it doesn't have to be a complicated one. Term Life Insurance underwritten by Anthem Life Insurance Company.



Pharmacy: Pharmacy is the most widely used benefit—4X more than medical—and often the first benefit members access.¹ Getting the most out of your pharmacy benefits can help keep you healthy and save you money.

- **Your covered medications:** To see if your drug is covered, go to anthem.com/pharmacyinformation and choose the link, **Colorado Select Drug List (Searchable)** or **(PDF)**.
- **Retail Pharmacies:** Your pharmacy benefit includes nearly 70,000 retail pharmacies nationwide. To see if your preferred pharmacy is in the plan's network, visit anthem.com/pharmacyinformation/rxnetworks.html.
- **Home Delivery:** Get your medicine delivered right to your door. People who use home delivery pharmacy are more likely to follow their drug treatment plan and have better health outcomes.

To learn more, call your representative.

To learn more, call your broker or Anthem representative. You can also view and compare plans online at **anthem.com**.

If you'd like a paper copy of this information by fax or mail, call your broker or Anthem representative.

Our retail and home delivery networks are owned and operated by our pharmacy benefit manager, Express Scripts.

¹ Retail Prescription Drugs Filled at Pharmacies (Annual per Capita) (accessed 2/16/2017): [kff.org](https://www.kff.org/); Ambulatory Care Use and Physician office visits, US Centers for Disease Control and Prevention (accessed 2/16/2017), <https://www.cdc.gov/nchs/fastats/physician-visits.htm>; <https://www.cdc.gov/nchs/fastats/drug-use-therapeutic.htm>; and <http://www.statista.com/chart/2689/americans-dont-like-visiting-the-doctor> (accessed June 17, 2015).

Answers to your questions

Why choose Anthem?

When you choose an individual or family insurance plan with Anthem, you'll have access to leading doctors and hospitals. It's important to us that you see the doctor you want and get the care you need.

You'll see the difference with Anthem. You can select great doctors, care centers and hospitals from our network of providers. You can also have a private video visit with a doctor or therapist on your smartphone, tablet or computer. It's one of the best ways for us to help support your health and the health of your family.

Access to preventive care

At Anthem, we believe that prevention is the best medicine. Preventive care is offered for as low as \$0 with no copay and no deductible to meet when received from doctors in your plan.

With us, you can also count on:

- Dedicated customer service.
- One source for all your benefits, including dental, vision and term life.
- A simple enrollment process.
- Resources to support your health care goals.

Why do I need coverage?

The short answer is ... life happens and it helps to be ready. No one plans to break an arm or catch pneumonia. That's why having a health care plan is so important. It helps you:

- Pay for those unexpected costs that come with a serious illness or injury.
- Get some important benefits like preventive care that can help you stay healthier and get more effective treatment.

Still not convinced? Here are three reasons why coverage is so important:

- 1 It's worth the price.** Have you ever thought about what the cost would be to have a major surgery without health insurance? Now picture adding that in with your mortgage/rent and monthly expenses. That's a case where monthly payments for coverage are small compared to footing the bill for a major unexpected cost.
- 2 It helps you stay on top of checkups.** When you have coverage, you'll be much more likely to use it to get your yearly checkups and tests that can catch issues early. Plans even include preventive care at no extra cost when you use doctors in your plan (in-network doctors).
- 3 It's an investment in you.** You insure your home and cars, so why would you put yourself at the bottom of the list? Think about how much it would cost to fix you if something serious were to happen.

Answers to your questions

What coverage do I need?

Choosing the right plan for you can be a challenge. We get that. So let's start with some questions to figure out what works best for you:

- **Does the plan meet your coverage needs?** How often do you see doctors and specialists? What prescription medications do you take regularly? Are you planning any procedures this year?
- **Is a Catastrophic plan an option?** If you're under age 30 (or are 30 or older with an approved hardship exemption from Healthcare.gov) you may qualify for a high-deductible, lower monthly payment, Catastrophic plan. Catastrophic plans can help protect you from worst-case scenarios like serious accidents or illnesses.

Plan choices

Metal Levels

- **Bronze:** You'll have lower monthly payments while being covered for check ups and preventive care. You could pay more out of pocket if you need more care, but if you don't expect to go to the doctor very much this year, Bronze may be a good bet. These health plans can be great for people who are younger with no dependents.
- **Silver:** You'll get health coverage that covers all the basics and more. You'll also get preventive care for \$0 with no copay and no deductible from in-network doctors. Silver plans on Connect for Health Colorado offer the greatest assistance for both tax credits and cost sharing subsidies if you qualify.

Can I afford it?

If you're thinking coverage might cost too much, you're not alone. But, what you might not know is that you may be able to get help paying for it. And a health insurance subsidy may be the answer. Don't know what a subsidy is? That's just a fancy word for getting financial help from the government to help you pay for your health care coverage.

You could be eligible for a subsidy, also called an advanced premium tax credit, to lower your monthly payment. You may also qualify for a plan where you'll pay less for your out-of-pocket costs.

Want to see if you qualify? Visit planfinder.connectforhealthco.com.

Other ways to help save money:



Check if your favorite doctor, hospital or other health care provider is in your plan. That way you can make sure you get your care at the lower or negotiated network rate.



You can also save money by only using the emergency room (ER) for emergencies. Head straight to the ER or call 911 for serious health issues. Otherwise, save yourself money and time by visiting your primary care doctor, an urgent care center, or LiveHealth Online for minor medical issues.

Health savings account (HSA)



If you like the idea of lowering your health care costs and your taxes, a **health savings account (HSA)** could be a good option for you.

With a qualified high-deductible plan, you can set up the HSA through a bank and fund it with your post tax dollars. Before selecting an HSA plan, check with your tax advisor to see if an HSA plan is right for you.

Answers to your questions

How do I find a doctor or hospital?

You can find an in-network doctor, hospital, dentist, pharmacy and more by using our **Find a Doctor tool**. It's quick and easy. Plus, you'll get the most from your health care coverage (and save money), if you choose a doctor or hospital in your plan. Follow these simple steps:

- 1 Go to **anthem.com**.
- 2 Choose **Individual & Family** at the top of your screen. Then under **Care** select **Find a Doctor**.
- 3 Scroll past Search as a Member to **Search as Guest**.
- 4 Choose **Search by Selecting a Plan or Network** and complete the form.

The difference between in-network doctors and out-of-network doctors

In-network Doctors:	Doctors and other health care providers who contract with us to provide care at discounted rates.
Out-of-network Doctors:	Doctors and other health care providers who are not contracted with the health plan.

What should I know about my network?

Depending on what type of plan you choose, your benefits, doctor and medical facility choices may be different:

- **Pathway and Mountain Enhanced networks:** With our health maintenance organization (HMO) plans, you have access to a wide range of doctors, health care providers and plans based on where you live in Colorado.

You have to choose a primary care doctor, but you don't need a referral to see other in-network doctors. HMOs don't offer out-of-network benefits, except for emergency and urgent care or when a service is preapproved. If you see doctors not in the plan for any other reason, you'll have to pay 100% out of pocket.

- With our **PPO Catastrophic** plan (available off the Marketplace only), you get access to our widest network of doctors and hospitals in Colorado. You choose a primary care doctor to manage your care needs, but you don't need referrals. This plan is available in most, but not all rating areas in Colorado, and is available to people under age 30 or who qualify for a hardship exemption. Keep in mind, this plan doesn't offer out-of-network benefits, except for emergency care. So, if you see doctors not in the plan for any other reason, you'll have to pay 100% out of pocket.

Anthem advantages

Making informed health care decisions for you and your family is simple with our website, mobile app and helpful tools, like Estimate Your Cost.

No matter which plan you choose, you can register at anthem.com or on the Anthem Anywhere mobile app to get personalized information about your health plan.



Use the self-service tools on our secure website to:

- See your claims and coverage details.
- Estimate your costs on common procedures, before you step into the doctor's office.
- Manage your prescription benefits and search the drug list that applies to your plan.
- Check the price of a drug or refill a prescription.
- Make your monthly payments online.



With our Anthem Anywhere mobile app, you can:

- Find a nearby doctor, specialist, urgent care center or hospital.
- Download a virtual member ID card.
- Manage your prescription drug benefits.

LiveHealth[®]
O N L I N E

You can also take advantage of resources like LiveHealth Online:

Talk to a doctor whenever, wherever with LiveHealth Online

Easy:

Connect to a doctor 24 hours a day, from a computer, tablet, or smartphone.

Face-to-face:

Chat by two-way video for common health issues.

Save:

On average members save up to \$201 for care, compared to ER, urgent care, or other health facilities.*

LiveHealth Online Psychology offers virtual counseling

Convenient:

Sessions go from 7 a.m. to 11 p.m., coast-to-coast.

Quick access:

Schedule a visit and be seen within four days, or on demand.

Same cost:

Cost-share is the same as it is for in-office Mental Health/Substance Use therapy benefits.

*Results based on internal LiveHealth Online study during 2014 and first quarter, 2015.

Anthem advantages

Plans include other features to help you and your family stay healthy at no additional cost.

- **24/7 Nurseline:** Our registered nurses can answer your health questions wherever you are – any time, day or night. All you have to do is call.
- **Care Support:** If you need extra care for ongoing or complex health issues, a case manager may call you. Your case manager can answer your questions, set up care with different doctors and help you use your health benefits.
- **MyHealth Advantage:** Avoid health issues, stay healthy and save money. This program tracks your health information to see if there's anything you can do to improve your health. If so, you'll get a personalized and confidential MyHealth Note in the mail.

Peace of mind when you travel.

Travel a lot? Don't worry. You're covered.



Whether you're traveling for work or on vacation, going to the ER or urgent care is the last thing you want to worry about. The good news is you don't have to! All of our plans cover medically necessary emergency and urgent care in all 50 states, even when you're not using your plan's doctors and hospitals.

Guest Membership/Away From Home Care when temporarily living out of state – HMO.

Will you or a family member be living away from home and outside of your health plan's service area for more than 90 days? With our HMO plans, we can cover you. Just ask for a guest membership (also known as Away From Home Care) to one of our affiliated Blue Cross and Blue Shield plans in that area. A guest membership lets you become a "guest" of that other health plan and enjoy its benefits and coverage. It comes in handy for students going to college in another state. After you're a member, call Guest Membership at 800-827-6422 to learn more. Guest memberships aren't available in all areas.

Simplified payments

We know life gets busy, so we're making it easier for you to pay your monthly payments.

- Set up electronic funds transfer (EFT) or bank draft.
- Enroll in WebPay to use with a Visa or MasterCard debit or credit card.
- Download our Anthem Anywhere app and pay with a credit card or your bank account. You can even set up autopay in the app.

You can set up automatic monthly payments with each option. Just make sure your card account information and expiration date stays up to date.

Plan benefit chart - HMO

The benefit information shown here is for in-network services.

Mountain Enhanced network plans are available in the following communities only: Archuleta county (Pagosa Springs), La Plata county (Durango), Mesa, Moffat, Montezuma county (Cortez), Rio Blanco, Summit county (Keystone/ Frisco/Breckenridge) and Eagle county (Vail Valley).

	Anthem Bronze Mountain Enhanced HMO 5000 (36VU)	Anthem Bronze Mountain Enhanced HMO 5800 (393M)	Anthem Bronze Mountain Enhanced HMO 6650 for HSA (36WT)
Network name	Mountain Enhanced	Mountain Enhanced	Mountain Enhanced
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$5,000	\$5,800	\$6,650
Individual out-of-pocket limit	\$7,900	\$7,900	\$6,650
Coinsurance (percentage may vary for some covered services)	40%	30%	0%
Preventive care ¹	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	\$50 copay per visit for the first 2 visits, then deductible and 40% coinsurance	\$45 copay per visit for the first 2 visits, then deductible and 30% coinsurance	Deductible, then 0% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then \$250 copay and 40% coinsurance	Deductible, then \$500 copay and 30% coinsurance	Deductible, then 0% coinsurance
Urgent care	\$100 copay	\$100 copay	Deductible, then 0% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then \$200 copay and 40% coinsurance	Deductible, then \$200 copay and 30% coinsurance	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then \$1,000 copay and 40% coinsurance	Deductible, then \$500 copay and 40% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1²: Level 1 / Level 2	\$20 copay / \$30 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2²: Level 1 / Level 2	\$60 copay / \$70 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3²: Level 1 / Level 2	\$150 copay / \$160 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	\$650 copay / \$660 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance
Physical and occupational therapy ³ (limits apply)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Speech therapy ³ (limits apply)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance

Please see Medical plans footnotes on page 15.

Plan benefit chart - HMO

The benefit information shown here is for in-network services.

	Anthem Bronze Pathway HMO 5000 (36UQ)	Anthem Bronze Pathway HMO 5800 (36UT)	Anthem Bronze Pathway HMO 6650 for HSA (36UW)
Network name	Pathway	Pathway	Pathway
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$5,000	\$5,800	\$6,650
Individual out-of-pocket limit	\$7,900	\$7,900	\$6,650
Coinsurance (percentage may vary for some covered services)	40%	30%	0%
Preventive care ¹	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	\$50 copay per visit for the first 2 visits, then deductible and 40% coinsurance	\$45 copay per visit for the first 2 visits, then deductible and 30% coinsurance	Deductible, then 0% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then \$250 copay and 40% coinsurance	Deductible, then \$500 copay and 30% coinsurance	Deductible, then 0% coinsurance
Urgent care	\$100 copay	\$100 copay	Deductible, then 0% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then \$200 copay and 40% coinsurance	Deductible, then \$200 copay and 30% coinsurance	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then \$1,000 copay and 40% coinsurance	Deductible, then \$500 copay and 40% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1²: Level 1 / Level 2	\$20 copay / \$30 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2²: Level 1 / Level 2	\$60 copay / \$70 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3²: Level 1 / Level 2	\$150 copay / \$160 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	\$650 copay / \$660 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance
Physical and occupational therapy ³ (limits apply)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Speech therapy ³ (limits apply)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance

Please see Medical plans footnotes on page 15.

Plan benefit chart - HMO

The benefit information shown here is for in-network services.

Mountain Enhanced network plans are available in the following communities only: Archuleta county (Pagosa Springs), La Plata county (Durango), Mesa, Moffat, Montezuma county (Cortez), Rio Blanco, Summit county (Keystone/Frisco/Breckenridge) and Eagle county (Vail Valley).

	Anthem Silver Mountain Enhanced HMO 2000 25% (3QUS)	Anthem Silver Mountain Enhanced HMO 2600 15% (3QUT)	Anthem Silver Mountain Enhanced HMO 5150 35% (3QUV)
Network name	Mountain Enhanced	Mountain Enhanced	Mountain Enhanced
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$2,000	\$2,600	\$5,150
Individual out-of-pocket limit	\$6,700	\$7,900	\$6,800
Coinsurance (percentage may vary for some covered services)	25%	15%	35%
Preventive care ¹	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	\$35 copay	\$40 copay per visit for the first 3 visits, then deductible and 15% coinsurance	\$35 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then \$250 copay and 25% coinsurance	Deductible, then \$500 copay and 15% coinsurance	Deductible, then 35% coinsurance
Urgent care	\$100 copay	\$100 copay	\$100 copay
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then \$200 copay and 25% coinsurance	Deductible, then \$500 copay and 15% coinsurance	Deductible, then 35% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then \$500 copay and 30% coinsurance	Deductible, then \$500 copay and 30% coinsurance	Deductible, then 35% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies
Retail pharmacy tier 1²: Level 1 / Level 2	25% coinsurance / 35% coinsurance	\$15 copay / \$25 copay	\$10 copay / \$20 copay
Retail pharmacy tier 2²: Level 1 / Level 2	25% coinsurance / 35% coinsurance	\$45 copay / \$55 copay	\$40 copay / \$50 copay
Retail pharmacy tier 3²: Level 1 / Level 2	25% coinsurance / 50% coinsurance	\$80 copay / \$90 copay	40% coinsurance / 50% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	25% coinsurance / 50% coinsurance	\$500 copay / \$510 copay	40% coinsurance / 50% coinsurance
Physical and occupational therapy ³ (limits apply)	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Speech therapy ³ (limits apply)	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance

Please see Medical plans footnotes on page 15.

Plan benefit chart - HMO

The benefit information shown here is for in-network services.

Mountain Enhanced network plans are available in the following communities only: Archuleta county (Pagosa Springs), La Plata county (Durango), Mesa, Moffat, Montezuma county (Cortez), Rio Blanco, Summit county (Keystone/ Frisco/Breckenridge) and Eagle county (Vail Valley).

	Anthem Silver Mountain Enhanced HMO 5300 25% (3QUU)	Anthem Silver Pathway HMO 2000 25% (3QT9)	Anthem Silver Pathway HMO 2600 15% (3QTA)
Network name	Mountain Enhanced	Pathway	Pathway
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$5,300	\$2,000	\$2,600
Individual out-of-pocket limit	\$6,800	\$6,700	\$7,900
Coinsurance (percentage may vary for some covered services)	25%	25%	15%
Preventive care ¹	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	\$35 copay	\$35 copay	\$40 copay per visit for the first 3 visits, then deductible and 15% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 25% coinsurance	Deductible, then \$250 copay and 25% coinsurance	Deductible, then \$500 copay and 15% coinsurance
Urgent care	\$100 copay	\$100 copay	\$100 copay
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 25% coinsurance	Deductible, then \$200 copay and 25% coinsurance	Deductible, then \$500 copay and 15% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then \$500 copay and 30% coinsurance	Deductible, then \$500 copay and 30% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: No deductible
Retail pharmacy tier 1²: Level 1 / Level 2	\$10 copay / \$20 copay	25% coinsurance / 35% coinsurance	\$15 copay / \$25 copay
Retail pharmacy tier 2²: Level 1 / Level 2	\$40 copay / \$50 copay	25% coinsurance / 35% coinsurance	\$45 copay / \$55 copay
Retail pharmacy tier 3²: Level 1 / Level 2	35% coinsurance / 50% coinsurance	25% coinsurance / 50% coinsurance	\$80 copay / \$90 copay
Retail pharmacy tier 4: Level 1 / Level 2	50% coinsurance / 50% coinsurance	25% coinsurance / 50% coinsurance	\$500 copay / \$510 copay
Physical and occupational therapy ³ (limits apply)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance
Speech therapy ³ (limits apply)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance

Please see Medical plans footnotes on page 15.

Plan benefit chart - HMO

The benefit information shown here is for in-network services.

	Anthem Silver Pathway HMO 5150 35% (3QTC)	Anthem Silver Pathway HMO 5300 25% (3QTB)	Anthem Catastrophic PPO 7900 (36X4)
Network name	Pathway	Pathway	Anthem PPO
Plan includes out-of-network coverage?	No	No	Yes
Individual deductible	\$5,150	\$5,300	\$7,900 / \$23,700 In-network / Out-of-network
Individual out-of-pocket limit	\$6,800	\$6,800	\$7,900 / \$23,700 In-network / Out-of-network
Coinsurance (percentage may vary for some covered services)	35%	25%	0% / 50% In-network / Out-of-network
Preventive care ¹	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	\$35 copay	\$35 copay	\$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance
Urgent care	\$100 copay	\$100 copay	Deductible, then 0% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1²: Level 1 / Level 2	\$10 copay / \$20 copay	\$10 copay / \$20 copay	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2²: Level 1 / Level 2	\$40 copay / \$50 copay	\$40 copay / \$50 copay	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3²: Level 1 / Level 2	40% coinsurance / 50% coinsurance	35% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	40% coinsurance / 50% coinsurance	50% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance
Physical and occupational therapy ³ (limits apply)	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance
Speech therapy ³ (limits apply)	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance

Please see Medical plans footnotes on page 15.

Plan benefit chart - HMO

The benefit information shown here is for in-network services.

	Anthem Catastrophic Pathway HMO 7900 (36VL)
Network name	Pathway
Plan includes out-of-network coverage?	No
Individual deductible	\$7,900
Individual out-of-pocket limit	\$7,900
Coinsurance (percentage may vary for some covered services)	0%
Preventive care ¹	No additional cost to you.
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	\$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 0% coinsurance
Urgent care	Deductible, then 0% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1²: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2²: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3²: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Physical and occupational therapy ³ (limits apply)	Deductible, then 0% coinsurance
Speech therapy ³ (limits apply)	Deductible, then 0% coinsurance

Please see Medical plans footnotes on page 15.

Medical plans benefit footnotes

1 Nationally recommended **preventive care services** from in-network providers have no copay, no coinsurance and no deductible requirement. Preventive and wellness services consist of certain services, including well-child care, immunizations, prostate-specific antigen (PSA) screenings, Pap tests, mammograms and more, recommended by the United States Preventive Services Task Force.









2 **Home delivery pharmacy** cost shares are 2.5 times the retail copay for Tier 1 drugs and 3 times the retail copay for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays.

3 **Physical, occupational or speech outpatient therapy** limited to up to 20 visits for each therapy per year for **rehabilitation services**. A separate 20 visit limit for each therapy per year applies to **habilitation services**. From birth until the member's sixth birthday, both of these benefits are provided as required by applicable law.

Understanding insurance terms

Let's take a look at some common insurance terms you probably see a lot.

Here's what they mean:

-  **Coinsurance:** Your percentage of the costs. After you meet your deductible, this is your percentage of costs each time you get care and then your plan covers the rest up to the maximum allowed amount. In-network providers agree to accept Anthem's maximum allowed amount as their charge.
-  **Copay:** This is a set dollar amount you pay for covered services, such as doctor visits. The amount can vary based on covered service. It's listed in your medical plan charts.
-  **Deductible:** This is the set dollar amount you pay before we begin paying for most covered health services you receive. It's listed in your benefit plan. **In-network** covered preventive services don't require a deductible. Your deductible applies to the calendar year (January 1 through December 31), even if your effective date (the date coverage begins) is later than January 1.
-  **Drug tiers:** Drugs on a drug list or formulary are typically arranged in tiers. Your cost depends on which drug tier your drug is in.
-  **In-network coverage:** This refers to doctors, hospitals, dentists, pharmacies and other care providers who are part of the plan's network or are in the plan. HMO plans only include coverage for in-network benefits, except for emergency and urgent care, ambulance services, or when a service is pre-approved. The PPO Catastrophic plan only includes coverage for in-network benefits, except for emergency care.
-  **Out-of-network coverage:** This refers to doctors, hospitals, dentists, pharmacies and other care providers who don't participate in the plan or network. HMO plans don't offer out-of-network benefits, except for emergency and urgent care, ambulance services, or when a service is pre-approved. The PPO Catastrophic plan doesn't offer out-of-network benefits, except for emergency care.
-  **Out-of-pocket limit:** This is the maximum amount you can pay out of your pocket for covered services each year. Once you reach that limit, which varies by plan, we cover the rest up to the maximum allowed amount. In-network providers agree to accept Anthem's maximum allowed amount as their charge.
-  **Plan name:** Plan name and contract code are found on the first row of the medical plan charts. Look for this when you're applying for a plan. The contract code is in parentheses after the plan name.

Ready to enroll? Let's get started.

Help is close at hand:



Call your broker or Anthem representative to enroll or learn more about our health care plans. Take a look at the **application** included with this brochure.



Visit our website at [anthem.com](https://www.anthem.com) and apply online.

You can buy health care plans once a year through an open enrollment period. This year, the open enrollment period runs from **November 1, 2018 - January 15, 2019**.


You may be able to change your health coverage outside of this open enrollment period if there are special qualifying events. Check with your broker or Anthem representative to see if you qualify or if you have other questions about eligibility.


We want you to be satisfied


After you enroll in one of our plans, you'll have access to your *Certificate of Coverage* or (*Certificate*) that explains the terms and conditions of coverage, including exclusions and limitations. You'll have 10 days to examine your *Certificate's* features. If you're not fully satisfied during that time, you may cancel your coverage and your premium will be refunded, minus any claims that were already paid.

Summary of benefits and services

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the *Certificate* may be continued in force or discontinued. For more complete details on what's covered and what isn't:

 Review the Certificate.

 Call your broker or Anthem representative

 Go to anthem.com.

To view a copy of both a ***Summary of Benefits and Coverage (SBC)*** and the ***CO SBC Supplement***, please visit sbc.anthem.com and select **NEXT** for Summaries in English or Spanish. Other languages can also be selected.

The health plans described in this document aren't eligible for a premium tax credit or subsidy/cost-sharing assistance. The Affordable Care Act (ACA) helps people with low or modest incomes pay for their health insurance with a premium tax credit or subsidy to help pay for their health insurance. You can only get financial help if you're eligible and you buy your individual health coverage through Connect for Health Colorado.

In compliance with the Affordable Care Act (ACA), the following plan changes may occur annually on January 1:

- Benefits
- Premiums (monthly payments)
- Deductibles, copays, coinsurance and out-of-pocket-limits

There may also be changes to our pharmacy and provider networks and prescription formulary/drug list during the year.

Important legal information

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

Eligibility

You can apply for coverage for yourself or with your family. You must be a resident of the State of Colorado and not entitled to or enrolled in Medicare Parts A/B and/or D. Family health coverage includes you, your spouse or domestic partner and any dependent children. Children are covered to the end of the month in which they turn age 26.

Eligibility for a catastrophic plan

You are eligible for this plan if you:

- are also under age 30 before the plan's effective date; or
- have received certification from Healthcare.gov that you qualify for a hardship exemption or don't have an affordable coverage option

Open enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and members may change benefit plans at that time.

Special enrollment and changes affecting eligibility

In addition to open enrollment, an individual can enroll during the special enrollment period. This is a period of time in which eligible individuals or their dependents can enroll after the open enrollment, typically due to an event such as marriage, birth, adoption, or other qualifying events as defined by law.

Depending on the event which triggered the special enrollment period, coverage may be effective as of the date of the qualifying event.

Effective date of coverage

The earliest effective date for the annual open enrollment period is the first day of the following benefit year. The actual effective date is determined by the date Anthem receives a complete application with the applicable premium payment.

Managing your care if you need to go to a hospital or get certain medical treatment

If you or a family member need certain types of medical care (for example: surgery, treatment in a doctor's office, physical therapy, etc.), you may want to know more about these programs and terms. They may help you better understand your benefits and how your health plan manages these types of care.

Utilization review

Utilization review is a program that is part of your health plan. It lets us make sure you're getting the right care at the right time. Our utilization review team, made up of licensed health care professionals such as nurses and doctors, does medical reviews. The team goes over the information your doctor has sent us to see if the requested surgery, treatment or

other type of care is medically necessary. The utilization review team checks to make sure the treatment meets certain clinical guidelines set by your health plan. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The utilization review team will let you and your doctor know as soon as possible. Decisions not to approve are put in writing. The written notice will include information on how to appeal the decision and about your rights to an independent medical review.

Reviewing where services are provided

A service must be medically necessary to be a covered service. The utilization review may include a review of the level of care, type of setting or place of service where services can be safely given to you. If services are given in a higher level of care or cost setting when they could be safely given in a lower level place of care or cost setting, they will not be determined to be medically necessary. The service(s), in that case, are being denied based on the review of where they are provided. When this happens the service(s) can be requested again in another setting or place of care and will be reviewed again for medical necessity. At times, a different type of provider or facility may need to be used in order for the service to be considered medically necessary.

Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a hospital but may be approved if provided on an outpatient basis in a Hospital setting.
- A service may be denied on an outpatient basis if taking place in a hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical center/facility, or in a physician's office.
- A service may be denied at a skilled nursing facility but may be approved in a home setting.

We can do medical reviews like this before, during and after a member's treatment. Here's an explanation of each type of review:

The pre-service review (done before you get medical care)

We may do a pre-service review before a member goes to the hospital or has other types of services or treatment. Here are some types of medical treatments that might call for a pre-service review:

- An inpatient hospital visit;
- An outpatient procedure;
- Tests to find the cause of an illness, like magnetic resonance imaging (MRI) and computed tomography (CT) scans;
- Certain types of outpatient therapy
- Durable medical equipment (DME), like wheelchairs, walkers, crutches, hospital beds and more

Important legal information

The concurrent review (done during medical care and recovery)

We do a concurrent review when you are in the hospital or are released and need more care related to the hospital stay. This could mean services or treatment, such as physical therapy or durable medical equipment. The utilization review team looks at the member's medical information at the time of the review to see if the treatment is medically necessary.

The post-service review (done after you get medical care)

We do a post-service review when you have already had surgery or another type of medical care. When the utilization review team learns about the treatment, they look at the medical information the doctor or provider had about you at the time the medical care was given. The team then can see if the treatment was medically necessary.

Case management

Case management is conducted by a licensed health care professional, who works with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

Precertification

Precertification is the process of getting approval from your health plan before you get services. This process lets you know if we will cover a service, supply, therapy or drug. We approve services that meet our standards for needed and appropriate treatment. The guidelines we use to approve treatment are based on standards of care in medical policies, clinical guidelines and the terms of your plan. As these may change, we review our precertification guidelines regularly. Precertification is a type of pre-service review.

Here's how getting precertification can help you out:

Saving time. Preauthorizing services is a process of verifying, in advance, whether a proposed treatment, service or supply is medically necessary and/or medically appropriate. The doctors in our network ask for prior authorization for our members.

Saving money. Paying only for medically necessary services helps everyone save. Choosing a doctor who's in our network can help you get the most for your health care dollar.

What can you do? Choose an in-network doctor. Talk to your doctor about your conditions and treatment options. Ask your doctor which covered services need prior authorization or call us to ask. The doctor's office will ask for prior authorization for you. Plus, costs are usually lower with an in-network doctor. If you choose an out-of-network provider, be sure to call us to get prior authorization. Out-of-network providers may not do that for you. It is important to understand that not all plans offer out of network coverage, with the exception of emergency or urgent care or ambulance services related to an emergency for transportation to a hospital or urgent care services received at an urgent care center. Please review the

Certificate in order to determine your benefits. Once you're a member, if you have a question about prior authorization, you can call the Member Service number on the back of your ID card.

In-network providers

In-network providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain covered services from providers located in the state of Colorado; however, the broadest benefits are provided for services obtained from a primary care doctor (PCP), specialty care doctor (SCP), or other in-network providers.

With our preferred provider organization (PPO) plans, you have the freedom to see any in-network doctor you choose. With our health maintenance organization (HMO) plans, you choose one of our in-network PCPs who helps to coordinate your care. When you need to see other in-network doctors, a referral from your PCP is not required.

Services you obtain from any provider other than a PCP, SCP or another in-network provider are considered an out-of-network service, except for emergency care or urgent care, or as an authorized service if you purchase one of our HMO plans.

Out-of-network providers

For HMO plans, services will only be covered services if rendered by providers located in the state of Colorado unless:

- The services are for emergency care, urgent care or ambulance services related to an emergency for transportation to a hospital or urgent care services received at an urgent care center, as specified in the Certificate; or
- The services are approved in advance by Anthem.

Covered services which are not obtained from a PCP, SCP or another in-network provider or not an authorized service will be considered a out-of-network service. The only exceptions are emergency care and urgent care or ambulance services related to an emergency for transportation to a hospital or urgent care services received at an urgent care center. In addition, certain services are not covered unless obtained from an in-network provider; see your Summary of Benefits. Emergency care from an out-of-network provider is based on the allowable charge determined by us. This means that you may be responsible for the difference between what we allow and what the provider chooses to bill.

For our PPO Catastrophic plan, covered services rendered by out-of-network providers are covered, but your share of the costs may be greater.

For services rendered by an out-of-network provider, you are responsible for:

- The difference between the actual charge and the maximum allowed amount plus any deductible and/or copayments/coinsurance;
- Services that are not medically necessary;

Important legal information

- Non-covered services;
- Filing claims;
- Higher cost-sharing amounts

Laws and rights that protect you

As a member, you have rights and responsibilities. You have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. You also have certain rights and responsibilities when receiving your health care. Visit this link to find more information on our website:

<http://www.anthem.com/health-insurance/customer-care/faq>.

Limitations

The specific limitations are spelled out in the terms of the particular plan, but some of the more common services limited by these plans are:

- Ambulance services (non-emergency transportation) – \$50,000 per occurrence if an out-of-network provider is used
- Hearing aids – 1 pair every 5 years for members under age 18
- Home health care – 28 hours per week
- Rehabilitative care (outpatient only) – An equal number of therapy visits are available for habilitative care (outpatient only)
 - Chiropractic care – 20 visits per member per year
 - Occupational therapy – 20 visits per member per year
 - Physical therapy – 20 visits per member per year
 - Speech therapy – 20 visits per member per year
- Skilled nursing facility – 100 days per year

Exclusions

This list includes some of the more common services not covered by these plans:

- Acupuncture, regardless of which type of provider performs the service
- Alternative or complementary medicine
- Artificial and mechanical devices
- Breast reduction or augmentation
- Care provided by a member of your family
- Care received in an emergency room that is not emergency care, except as described in the Certificate's exclusions
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services)

- Comfort and/or convenience items
- Compound drugs except as stated in your Certificate
- Corrective eye surgery
- Cosmetic surgery and/or treatment that's primarily intended to improve your appearance
- Custodial ordered care as described in the Certificate's exclusions (this exclusion does not apply to hospice care)
- Dental, except as described in the Certificate
- Educational/training services
- Experimental or investigative treatment and any resulting complications
- Feet – surgical treatment
- Foot care – routine
- In-vitro fertilization (IVF) as described in the Certificate's exclusions
- Nutritional and dietary supplements, over-the-counter drugs, devices or products
- Physical fitness such as health club memberships, exercise equipment, etc.
- Prescriptions for infertility treatment, except where coverage is specifically required by law.
- Services we determine aren't medically necessary
- Teeth – congenital anomaly treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in the Certificate or as required by law
- Teeth, jawbone, gums – treatment of the teeth, jawbone or gums that are required as a result of a medical condition except as expressly required by law or specifically stated in the Certificate as a covered service
- Vein treatment – treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes
- Vision, except as described in the Certificate
- Weight loss programs/surgery or treatment of obesity, as specified in the Certificate
- Workers' compensation

A high-deductible health plan is not a health savings account (HSA). An HSA is a separate arrangement between an individual and a qualified financial institution. To take advantage of tax benefits, an HSA needs to be established. This brochure provides general information only and is not intended to be a substitute for the advice of a qualified tax professional.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to

Important legal information

offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (1-855-383-7249). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number listed above.

Spanish

Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (1-855-383-7249). (TTY/TDD: 711)

Amharic

ይህንን ሰነድ ለመረዳት በአማራጭ ቋንቋ እርዳታ ማግኘት ከፈለጉ፣ የአባል አገልግሎቶች ቁጥርን (1-855-383-7249) በመደወል ያለምንም ክፍያ ማግኘት ይችላሉ። (TTY/TDD: 711)

Arabic

إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة. دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (1-855-383-7249) (TTY/TDD: 711)

Bassa

Ɔ jũ ké m̀ d̀yì gbo-kpá-kpá m̀ó b́é m̀ ké céè-d̀è n̄ià k̀e m̀úin ẃó d̀é b̄āā-w̄ēin w̄ùd̀ù d̀ò m̀ú n̄i, m̀ b̄ēin ɔ z̄òò d̀ȳiin d̀é Mébà j̄è gbo-gm̀ò Kpòè n̄òbà n̄ià k̀e <1-855-383-7249> d̀á d̀á m̀ú. M̀ se w̄id̄i k̀àkò d̀ò p̄ēin mu. (TTY/TDD: 711)

Chinese

如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(1-855-383-7249)請求免費協助。(TTY/TDD: 711)

Farsi

در صورتی که برای درک این سند به زبانی دیگر نیازمند کمک هستید، می‌توانید بدون هیچ هزینه اضافی این را درخواست کنید. برای این کار با مرکز خدمات اعضا به شماره 1-855-383-7249 تماس بگیرید. (TTY/TDD: 711)

French

Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 1-855-383-7249. (TTY/TDD: 711)

German

Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (1-855-383-7249). (TTY/TDD: 711)

Igbo

Ọ bụrụ na ị chọrọ enyemaka ịjị ghotà dokwmentị a n'asụsụ dị iche, ị nwere ike ịrịọ ya na akwughị ugwo ọ bụla ọzọ site na ikpọ nomba Ọrụ Onye Otu (1-855-383-7249). (TTY/TDD: 711)

Japanese

この書面を他の言語で理解するための支援が必要な場合には、メンバーサービス番号 (1-855-383-7249) に電話して支援を求めることができます。追加費用はかかりません。(TTY/TDD: 711)

Korean

다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(1-855-383-7249)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Nepali

यदि तपाईंलाई यो कागजात कुनै अर्को भाषामा बुझ्न सहायता चाहिएमा, तपाईंले सदस्य सेवा नम्बर (1-855-383-7249) मा कल गरेर कुनै अतिरिक्त खर्च बिना यसको लागि अनुरोध गर्न सक्नुहुन्छ। (TTY/TDD: 711)

Oromo

Sanada kana afaan kan biroota hubachuuf yoo gargaarsa barbaadde lakkoofsa bilbilaa tajaajila miseensaa (Member Services) (1-855-383-7249) waraqaa eenyummaa kee irra jiru irratti bilbiluudhaan kaffaltii dabalataa malee gaafachuu dandeessa. (TTY/TDD: 711)

Get help in your language

Russian

Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (1-855-383-7249). (TTY/TDD: 711)

Tagalog

Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (1-855-383-7249). (TTY/TDD: 711)

Vietnamese

Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (1-855-383-7249). (TTY/TDD: 711)

Yoruba

Tí o bá nílò ìrànwọ́ kí àkọsílẹ̀ yìí le yé ọ ní èdè míràn, o le bèrè rẹ láìsí àfikún owó nípa pípe Nọmbà Àwọn ipèsè ọmọ-ẹgbẹ (1-855-383-7249). (TTY/TDD: 711)



So that's how it all works.

Still have questions? Just ask. We're here to help.

To learn more, call Anthem or your representative. You can also view and compare plans online at [anthem.com](https://www.anthem.com).

If you'd like a paper copy of this information by fax or mail, call Anthem or your representative.

Copies of Colorado network access plans are available on request from member services or can be obtained by going to [anthem.com/co/networkaccess](https://www.anthem.com/co/networkaccess).

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

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Your HSA:

*Enjoy the advantages of opening
a Health Savings Account (HSA)
from BenefitWallet®*

A Health Savings Account can help you pay for health care expenses including prescriptions. Plus, you can claim your HSA contributions as tax deductions, earn interest on your money and roll over the year-end balance.

To realize your plan's full power, consider selecting a qualified high-deductible health plan with an HSA. Our partner, BenefitWallet, administers our HSA solution with The Bank of New York Mellon as the custodian. Setting up your account with BenefitWallet is easy and it comes with built-in advantages and conveniences like:

- A single Customer Service contact for the health plan and your HSA
- A single online health site to access your plan benefit information and account details
- Several payment and deposit options, including debit cards, checks and automatic fund transfers
- Ability to save your receipt images online
- Competitive interest rates and investment opportunities for the funds in your account
- iPhone®, iPad® and Android™ apps for access anywhere
- Health Topics encyclopedia of more than 1,500 ailments
- Medication Advisor for drugs and pharmacy identifier
- Treatment Cost Advisor for common medical conditions
- FDIC-insured checking account with the custodian, The Bank of New York Mellon (BNY Mellon)

Note: You also have the option of using a different financial institution to set up your Health Savings Account.

Set up is easy

Simply make the selection on your application form and we'll send you welcome materials to get you started. Account registration instructions are included. It's that simple.



A closer look at your BenefitWallet HSA

BenefitWallet Welcome Materials

If you make the selection on your application form, your HSA will automatically be set up - no set-up fee required. You'll soon receive HSA welcome materials with all of the instructions for opening and using your account. A separate application for your account is only required if you choose an HSA administrator other than BenefitWallet.

Interest and investments

You'll earn interest on your HSA funds and have the chance to invest your funds as long as you keep a minimum \$1,000 HSA balance. Investment options include a number of mutual fund families. Once you're ready to invest, log in to your account and select "Investments" from the Quick Links menu or contact the BenefitWallet Service Center at **1-866-686-4798** or **1-855-545-4168** (for TDD callers) Mon - Fri 8 a.m. to 11 p.m. (ET); Sat - Sun 9 a.m. to 6 p.m. (ET).

Debit cards, checkbooks and online bill pay

Use your VISA debit card, your HSA checkbook or online bill pay (provided by BenefitWallet) to pay your doctor or pharmacy directly for eligible medical expenses — or to reimburse yourself for qualified medical expenses paid out of pocket.

Deposits to your account

You can make your deposits online or with a mobile app. You can also send a check and deposit slip to the address printed on your deposit slip. Deposit slips can be found at the back of the checkbook, online through the Help Center or through the BenefitWallet Service Center. In addition, you can set up an electronic funds transfer between your bank and BenefitWallet for one-time or recurring account contributions.

Account activity statement

Regularly, you'll receive an electronic statement from BenefitWallet that shows all your account activity. Your monthly statement is free if you open your account electronically. You can receive a paper statement for an additional fee of \$1.25 per month. Visit anthem.com or call your dedicated Customer Service line to learn how to elect this option. You'll also receive *IRS 1099* and *IRS 5498* forms from BNY Mellon near tax time to help with tax preparation.

BenefitWallet HSA fee and rate schedule

A *Deposit Agreement* and *Disclosure Statement*, along with a *Rate and Fee Sheet* will be made available to you by BenefitWallet. Please refer to those documents for the complete terms and conditions related to your account.

As appealing as these options may sound, you should still talk to your tax advisor when trying to maximize financial benefits for your personal situation.

Banking fees	
Monthly account fee	\$2.95
First two debit cards, debit card transactions, first checkbook, check writing, online bill pay, electronic transfers	no charge
ATM transactions	\$2
Card replacement Duplicate check	\$5
Check reorder	\$10
Nonsufficient funds	\$25
Stop-check service	\$25
Periodic paper statement	\$1.25

This is what the IRS requires if you want to open a Health Savings Account:

- You must be covered by an HSA-compatible, high-deductible health plan.
- You must be a U.S. resident, and not a resident of Puerto Rico or American Samoa.
- You cannot be covered by any other medical plan that is not an HSA-compatible, high-deductible health plan.
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent on another individual's tax return.
- If you are a veteran, you may not have received veteran's benefits within the last three months.
- You cannot be active military.
- Your spouse cannot be enrolled in an FSA plan.

Xerox HR Solutions, LLC an independent corporate entity, provides the BenefitWallet product and related banking administration on behalf of Anthem.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield of Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare Health Services Insurance Corporation (CompCare) or Wisconsin Collaborative Insurance Corporation (WCIC). CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Take control of your total health with the right dental and vision coverage

The mouth and eyes are important parts of your body and your health. They can show early warning signs of disease – so regular dental and vision checkups help you stay healthy. That's why taking care of your total health requires not just medical coverage, but also dental and vision plans.

- You've probably heard before that dental health is an important part of overall health. In fact, 90% of the body's diseases first show signs and symptoms in the mouth.*
- Routine eye checkups are about more than making sure you can see clearly. They're important to health, safety and learning. Even if you think you have 20/20 vision, it's key that you're checked regularly – at every age.
- Eye exams can detect major health problems like diabetes, high blood pressure and heart disease.** Some eye diseases have no warning signs. So people may not even know their vision is at risk.***

Getting the dental and vision plans you need

Off-exchange, standalone coverage from Anthem Blue Cross and Blue Shield (Anthem) can help you get the dental and vision care you need for your total health. Many of our dental plans cover you 100% for exams, cleanings and x-rays. All of our vision plans cover you for yearly eye exams.

All-in-one or separate plans?

You can buy a medical plan that includes dental and vision benefits — or you can buy separate plans. You may want to think about buying your dental and vision separate from your medical plan. Separate plans usually offer more choices and may have more benefits to meet your needs. The main differences are in how you apply for coverage and how you are billed.



Anthem dental plans

We offer a variety of individual and family dental plan options to fit your needs and budget. These plans include:

- Anthem Dental Family Value
- Anthem Dental Family
- Anthem Dental Family Enhanced
- Dental Prime for individuals and families

Anthem has one of the largest dental preferred provider organization (PPO) networks in the country.^{*} Plus, we work with in-network dentists to get deep discounts for you. By seeing an in-network dentist, you can save an average of 25% to 32% on covered dental services.[^]

Tools that put a smile on your face

We offer some great online tools to help you better understand your dental health. Once you're a member, log in to **anthem.com** to access:



Ask a Hygienist

Email questions to licensed dental professionals and get quick, private, personalized advice at no extra cost.



Dental Cost Estimator

Help estimate your costs for dental procedures and services in the ZIP code where you get care.



Dental Health Assessment

Get feedback based on your responses to a few questions to help you keep a healthy smile.

Blue View Vision plans

Our Blue View VisionSM plans are available to purchase with any Anthem medical and/or dental plan. With all Blue View Vision plans, you can choose from more than 38,000 eye doctors at over 27,000 locations.[†] So you can get your eye care and eye wear just about anywhere. You can call or go online at Glasses.com, ContactsDirect or 1-800 CONTACTS®, visit a participating private practice eye doctor, or go in-store to LensCrafters®, Sears OpticalSM, Target Optical®, JCPenney® Optical and most Pearle Vision® locations.

You'll enjoy the convenience of having just one ID card when you purchase your medical, dental and/or vision plans with Anthem. You'll also get just one combined bill for all your Anthem plans.

How does health care reform affect dental and vision coverage?

Health care reform, officially known as the Affordable Care Act (ACA), requires that all Americans have a minimum amount of health insurance. This includes a list of 10 essential health benefits that must be covered by health insurance carriers. One of these is pediatric services, including dental and vision coverage.

Here's how the ACA relates to dental and vision coverage for children:

Dental

In some states, pediatric dental benefits are required to be included in ACA-compliant medical plans sold off the Marketplace (also known as the exchange). In other states, these benefits can be offered in medical plans off the Marketplace or can be provided through a separate stand-alone policy that is sold with the medical plan.

Vision

Pediatric vision coverage will be included with all ACA-compliant medical plans offered on and off the Marketplace.

Pediatric dental essential health benefits

Pediatric dental coverage is included in nearly all of our individual medical plans as of January 2014.

You have two options for buying pediatric dental essential health benefits:

- A medical plan that has pediatric dental essential health benefits coverage
- A stand-alone dental plan that includes pediatric dental essential health benefits coverage.

Pediatric vision essential health benefits

These benefits provide exams and vision materials (lenses and frames) for children.

Our plans use Blue View VisionSM providers, which include retailers such as Glasses.com, ContactsDirect or 1-800 CONTACTS®, LensCrafters®, Sears OpticalSM, Target Optical®, JCPenney® Optical and most Pearle Vision® locations. With these plans:

- Covered children can choose from a selection of frames and contact lenses.
- Glasses with Transitions® lenses (to protect eyes from UV rays) and polycarbonate lenses with scratch coating (to protect lenses from damage) are available at no extra charge.

Should I buy “on the Marketplace” or “off the Marketplace”?

Connect for Health Colorado (the name of your state's Marketplace) was created as part of the ACA. This is the online marketplace where you can purchase medical coverage.

If you're eligible for financial assistance to help pay for your medical coverage...and want to use it, you must get your medical plan through Connect for Health Colorado.

To learn more, visit your state's exchange website at **ConnectforHealthCO.com**.

If you're not eligible for financial assistance, and you are shopping around for a dental or vision plan... you don't have to buy plans on Connect for Health Colorado. You can still buy coverage as you have in the past, through a broker or agent or directly from an insurance company. Because there are rules for plans on the exchange, you may find that plans not on the exchange offer you more choices.

Anthem Dental Family Value, Anthem Dental Family and Anthem Dental Family Enhanced plans

Our plans offer these advantages:

- You will not be charged premiums for more than three children.
- For children, families will not be charged more than twice the out-of-pocket limit, regardless of how many children are in the family.
- The Anthem Dental Family Value, Anthem Dental Family and Anthem Dental Family Enhanced plans cover everyone.

Cost shares show what the member pays	Anthem Dental Family Value		Anthem Dental Family	
	(Dependents age 18 and younger)	(Adults age 19+)	(Dependents age 18 and younger)	(Adults age 19+)
	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network
Dental network	Dental Prime	Dental Prime	Dental Prime	Dental Prime
Deductible (per person, all services)	\$50	\$50	\$50	\$50
Annual maximum (per person)	None	\$750	None	\$750
Annual out-of-pocket limit	\$350 ¹ / None	None	\$350 ¹ / None	None
Diagnostic and preventive	No waiting period	No waiting period	No waiting period	No waiting period
Cleaning, exams, x-rays	0% / 30% coinsurance	0% / 50% coinsurance	0% / 30% coinsurance	0% / 50% coinsurance
Extra cleaning	Not covered	Not covered	Not covered	Not covered
Basic services	No waiting period	6-month waiting period	No waiting period	6-month waiting period
Fillings	40% / 50% coinsurance	50% / 75% coinsurance	40% / 50% coinsurance	50% / 75% coinsurance
Brush biopsy	Not covered	Covered	Not covered	Covered
Complex and major services	No waiting period	Not covered	No waiting period	12-month waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	50% / 50% coinsurance ³	Not covered	50% / 50% coinsurance ³	70% / 85% coinsurance
Prosthetics (crowns, dentures, bridges)	50% / 50% coinsurance ³	Not covered	50% / 50% coinsurance ³	70% / 85% coinsurance
Medically necessary orthodontia	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	Not covered
Cosmetic orthodontia	Not covered	Not covered	Not covered	Not covered
International emergency dental program	Included	Included	Included	Included
Blue View Vision	Available	Available	Available	Available

1 Per child, up to \$700 per family.
2 Except 12-month waiting period for cosmetic orthodontia.
3 Coverage for pediatric children does not cover periodontic or prosthetic services.
4 \$1,000 lifetime maximum for cosmetic orthodontia.
Note: There are currently no Dental Prime-contracted dentists in Archuleta, Baca, Chaffee, Cheyenne, Crowley, Gilpin, Hinsdale, Jackson, Kiowa, Lake, Mineral, Moffat, Park, Pitkin, Rio Blanco, Routt, Saguache, San Juan, Sedgwick, Washington and Yuma counties.
out-of-network dentists will bill you for amounts over what your plan pays, up to their usual charge. The procedures listed here are a sample of covered service for members. If you need help to figure out the highest amount payable to an out-of-network dentist, call us at the number on your ID card.
Note: This is only a brief description of some plan benefits. Please refer to the Booklet for more complete details including benefits, limitations and exclusions.

Our dental plans come with the International Emergency Dental Program[‡]

If you travel outside of the U.S., you still have access to emergency dental services. With one call, we can help you find a credentialed, English-speaking dentist for your urgent dental care needs. We can even help with translation services when you call the dentist's office. Services you get through this program don't count toward your yearly limit, if your plan has one.

Dental Prime for individuals and families

Our Dental Prime plans cover routine care (like exams, cleanings and x-rays) with no waiting periods, so you can use those benefits right away. Because there are three plan options, you can choose a plan that fits your needs and budget.

Anthem Dental Family Enhanced		Dental Prime Plan A	Dental Prime Plan B	Dental Prime Plan C
(Dependents age 18 and younger)	(Adults age 19+)			
In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network
Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime
\$25	\$50	None	\$50	\$50
None	\$1,000	\$500	\$1,000	\$1,250
\$350 ¹ / None	None	None	None	None
No waiting period	No waiting period	No waiting period	No waiting period	No waiting period
0% / 20% coinsurance	0% / 50% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance
Not covered	Not covered	1 extra cleaning per year for those who are pregnant or diabetic	1 extra cleaning per year for those who are pregnant or diabetic	1 extra cleaning per year for those who are pregnant or diabetic
No waiting period	6-month waiting period	Not covered	6-month waiting period	6-month waiting period
20% / 40% coinsurance	20% / 60% coinsurance	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
Not covered	Covered	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
No waiting period ²	12-month waiting period	Not covered	12-month waiting period	12-month waiting period
20% / 50% coinsurance	50% / 75% coinsurance	Not covered	50% / 50% coinsurance	50% / 50% coinsurance
50% / 50% coinsurance ³	50% / 75% coinsurance	Not covered	Not covered	50% / 50% coinsurance
50% / 50% coinsurance	Not covered	Not covered	Not covered	Not covered
50% / 50% coinsurance ⁴	Not covered	Not covered	Not covered	Not covered
Included	Included	Included	Included	Included
Available	Available	Available	Available	Available

Find a dentist

To find a dentist near you, go to [anthem.com/findadoctor](https://www.anthem.com/findadoctor).

Blue View Vision coverage available

You can add Blue View VisionSM benefits to your dental plan. These plans feature:

- **A broad, convenient group of national providers** — Blue View Vision providers include more than 36,000 private practice doctors at over 27,000 locations.[†] This includes online choices through Glasses.com, ContactsDirect or 1-800 CONTACTS[®] in addition to the nation's leading retail stores like LensCrafters[®], Sears OpticalSM, Target Optical[®], JCPenney[®] Optical and most Pearle Vision[®] locations.
- **A complete picture of your health between your eye doctor and your primary care doctor** — when you have a medical plan with us, every time you get care through our network, it becomes part of your health history. With Blue View Vision, your network eye doctor can access your health history information — including patient summaries, diagnoses, lab results and prescriptions. They can also securely share relevant eye health information back to your primary care doctor, while protecting your personal information. This approach helps all of your doctors in the network gain a better understanding of your whole health — leading to better, more holistic care.
- **“Add-ons” at no extra charge** — factory scratch coating on eyeglass lenses is included at no extra cost. Transitions[®] and polycarbonate lenses for children younger than 19 can be added at no extra cost.
- **Discounts for other “add-ons”** — includes Transitions lenses for adults at a fixed price, as well as tiered pricing for premium progressive lenses and premium anti-reflective coatings. This cuts down on your out-of-pocket costs.
- **Value-added savings^{\$}** — including 15% to 40% off on unlimited purchases of most extra pairs of eye wear, conventional contact lenses, lens treatments, specialized lenses and various accessories — even after you've used all of your covered benefits.

Blue View Vision Bundled plan

Our current Blue View Vision **Bundled** plan has not changed. The Bundled plan can only be purchased in combination with any off the Marketplace Anthem individual medical or dental plan. The Bundled plan cannot be purchased on a stand-alone basis.

Blue View Vision Enhanced, Plus and Value plans

Our stand-alone Blue View Vision **Enhanced**, **Plus** and **Value** plans are designed with your lifestyle in mind and can be purchased with or without a medical and/or dental plan. You can choose the plan that gives you the most value from your benefits. See your options on the next page.

Cost savings example

You'll see that when you have a Blue View Vision plan from Anthem, it often pays for itself — and then some. When it comes to Blue View Vision, seeing isn't just believing. Seeing is saving, too!

	Retail	Benefit	Copay	Member pays
Exam	\$80	Covered	\$20	\$20
Frame	\$130	\$130 allowance	N/A	\$0
Single vision lenses	\$80	Covered		\$20
Scratch coating	\$22	Included	N/A	\$0
Progressive premium tier 1	\$140	Upgrade	N/A	\$86
Polycarbonate lenses	\$55	Upgrade	N/A	\$40
Anti-reflective premium tier 2	\$100	Upgrade	N/A	\$88
Transitions lenses	\$110	Upgrade	N/A	\$75
Total purchase	\$717			\$308

Member saves \$409

Blue View Vision plans

Blue View Vision Bundled*		
Vision care services	Benefit frequency	In-network benefit
Eye exam (with dilation as needed)	Once every 12 months	\$20 copay
Standard plastic (CR39) lenses¹	Once every 24 months	
Single vision		\$20 copay
Bifocal		\$20 copay
Trifocal		\$20 copay
Contact lenses	Once every 24 months	
Elective (conventional and disposable)		\$80 allowance
Non-elective		Covered in full
Frames	Once every 24 months	\$130 allowance

* Blue View Vision **Bundled** can only be purchased with a medical and/or dental plan.

Blue View Vision Enhanced**		
Vision care services	Benefit frequency	In-network benefit
Eye exam (with dilation as needed)	Once per calendar year	\$10 copay
Standard plastic (CR39) lenses¹	Once per calendar year	
Single vision		\$10 copay
Bifocal		\$10 copay
Trifocal		\$10 copay
Contact lenses	Once per calendar year	
Elective (conventional and disposable)		\$150 allowance
Non-elective		Covered in full
Frames	Once per calendar year	\$150 allowance

** Blue View Vision **Enhanced** can be purchased with or without a medical and/or dental plan.

Blue View Vision Plus**		
Vision care services	Benefit frequency	In-network benefit
Eye exam (with dilation as needed)	Once per calendar year	\$10 copay
Standard plastic (CR39) lenses¹	Once per calendar year	
Single vision		\$20 copay
Bifocal		\$20 copay
Trifocal		\$20 copay
Contact lenses	Once per calendar year	
Elective (conventional and disposable)		\$130 allowance
Non-elective		Covered in full
Frames	Once every other calendar year	\$130 allowance

** Blue View Vision **Plus** can be purchased with or without a medical and/or dental plan.

Blue View Vision Value**		
Vision care services	Benefit frequency	In-network benefit
Eye exam (with dilation as needed)	Once per calendar year	\$20 copay
Standard plastic (CR39) lenses¹	Once per calendar year	
Single vision		\$20 copay
Bifocal		\$20 copay
Trifocal		\$20 copay
Contact lenses	Once per calendar year	
Elective (conventional and disposable)		\$80 allowance
Non-elective		Covered in full
Frames	Once every other calendar year	\$130 allowance

** Blue View Vision **Value** can be purchased with or without a medical and/or dental plan.

1 Factory scratch coating is covered at no extra cost. Polycarbonate and Transitions lenses are covered for children under age 19.

Save time and money with smart provider choices

While all PPO plans allow you to see any doctor, you can save money by choosing an in-network doctor.

	In-network dentist	Out-of-network dentist
What you pay the dentist	<ul style="list-style-type: none">◦ Your deductible◦ The percentage that's not covered by your insurance	<ul style="list-style-type: none">◦ Your deductible◦ The percentage that's not covered by your insurance◦ The difference between what the dentist charges and the total amount we allow to be paid for a service
Claims paperwork	<ul style="list-style-type: none">◦ Your dentist sends claims to us◦ We pay the dentist directly	<ul style="list-style-type: none">◦ You or your dentist may submit your claims to us◦ We pay you or your dentist for covered expenses

You may pay more for care if you choose an out-of-network doctor. Here's why:

- In-network doctors have agreed, by contract, to special payment rates for services and cannot charge you more than these negotiated rates. If you have coinsurance or a deductible, you pay those amounts.
- Out-of-network doctors don't have a contract with us. They can charge you the difference between the total amount we allow to be paid for a service and the amount they normally charge for a service (plus your coinsurance or deductible). That means higher costs for you.

How to enroll

Sign up today for our dental and vision plans!

Online: Go to [anthem.com](https://www.anthem.com) and select **Shop For Insurance** to get your free quote and enroll.

Paper: Fill out and sign the appropriate form. Then, give the form to your broker or agent or mail it to us at the address listed on the form.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:

If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-453-7031 / 855-383-7249). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish

Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-453-7031 / 855-383-7249). (TTY/TDD: 711)

Amharic

ይህንን ሰነድ ለመረዳት በአማራጭ ቋንቋ እርዳታ ማግኘት ከፈለጉ፣ የአባል አገልግሎቶች ቁጥርን (855-453-7031 / 855-383-7249) በመደወል ያለምንም ክፍያ ማግኘት ይችላሉ። (TTY/TDD: 711)

Arabic

إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء. (855-453-7031 / 855-383-7249) (TTY/TDD: 711)

Bassa

Ɔ jũ ké n̄ d̄y gbo-kpá-kpá m̄ó b̄é n̄ ké céé-d̄è n̄ià k̄e múin w̄ó d̄é b̄āā-w̄ēin w̄ùd̄ù d̄ò mú n̄i, n̄ b̄ēin ɔ z̄òò d̄ȳin d̄é M̄éba j̄è gbo-gm̄ò Kp̄òè n̄òb̄à n̄ià k̄e <855-453-7031 / 855-383-7249> d̄á d̄á mú. M̄ se w̄id̄i k̄àk̄ò d̄ò p̄ēin mu. (TTY/TDD: 711)

Chinese

如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-453-7031 / 855-383-7249)請求免費協助。(TTY/TDD: 711)

Farsi

در صورتی که برای درک این سند به زبانی دیگر نیازمند کمک هستید، می‌توانید بدون هیچ هزینه اضافی این را درخواست کنید. برای این کار با مرکز خدمات اعضا به شماره 855-453-7031 / 855-383-7249 تماس بگیرید. (TTY/TDD: 711)

French

Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-453-7031 / 855-383-7249. (TTY/TDD: 711)

German

Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (855-453-7031 / 855-383-7249). (TTY/TDD: 711)

Igbo

Ọ bụrụ na ị chọrọ enyemaka ịji ghotà dokwmentị a n'asụsụ dị iche, ị nwere ike iriọ ya na akwughị ugwo ọ bụla ozo site na ịkpọ nomba Ọrụ Onye Otu (855-453-7031 / 855-383-7249). (TTY/TDD: 711)

Japanese

この書面を他の言語で理解するための支援が必要な場合には、メンバーサービス番号 (855-453-7031 / 855-383-7249) に電話して支援を求めることができます。追加費用はかかりません。(TTY/TDD: 711)

Korean

다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-453-7031 / 855-383-7249)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Nepali

यदि तपाईंलाई यो कागजात कुनै अर्को भाषामा बुझ्न सहायता चाहिएमा, तपाईंले सदस्य सेवा नम्बर (855-453-7031 / 855-383-7249) मा कल गरेर कुनै अतिरिक्त खर्च बिना यसको लागि अनुरोध गर्न सक्नुहुन्छ। (TTY/TDD: 711)

Oromo

Sanada kana afaan kan biroodhaan hubachuuf yoo gargaarsa barbaadde lakkoofsa bilbilaa tajaajila miseensaa (Member Services) (855-453-7031 / 855-383-7249) waraqaa eenyummaa kee irra jiru irratti bilbiluudhaan kaffaltii dabalataa malee gaafachuu dandeessa. (TTY/TDD: 711)

Russian

Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-453-7031 / 855-383-7249). (TTY/TDD: 711)

Tagalog

Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-453-7031 / 855-383-7249). (TTY/TDD: 711)

Vietnamese

Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-453-7031 / 855-383-7249). (TTY/TDD: 711)

Yoruba

Tí o bá nílò ìrànwọ́ kí àkọsílẹ̀ yìí le yé ọ ní èdè míràn, o le bèrè rẹ láísí àfikún owó nípa pípe Nọmbà Àwọn ìpèsè ọmọ-ẹgbẹ (855-453-7031 / 855-383-7249). (TTY/TDD: 711)

Notes

Notes

Notes



It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This is only a brief description of some plan terms and benefits. Please refer to your Booklet for more complete details, including benefits, limitations and exclusions.

* Academy of General Dentistry Know Your Teeth website: *Warning Signs in the Mouth Can Save Lives* (accessed August 2015); knowyourteeth.com.

**All About Vision website: *Why Are Eye Exams Important?* (May 2011): allaboutvision.com/eye-exam/importance.htm.

***American Academy of Ophthalmology website: Eye Diseases (March 13, 2008) geteyesmart.org.

± Network data from Strenuus, August 2016.

Δ Internal data, 2015.

† Blue View Vision internal data, 2016.

‡ The International Emergency Dental Program is managed by DeCare Dental. DeCare Dental is an independent company offering dental management services to Anthem Blue Cross and Blue Shield.

§ Laws in some states may prohibit in-network providers from discounting products and services that are not covered benefits.

Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess.

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

Individual dental and vision premiums for Colorado



For policies with effective dates of January 1, 2019 through December 31, 2019

We know that you have choices when it comes to health care coverage. Anthem Blue Cross and Blue Shield (Anthem) gives you access to complete dental coverage and one of the largest dental networks in the state. But cost is important to you, too.

Because insurance can be a big part of your budget, we make every effort to keep our costs low — so you pay less for coverage. The price you pay for your dental premium depends on several things, including how much dental care costs and where you live.

Anthem Dental plans

The child/children rates shown in the charts below are defined as dependent children ages 0-18. Any enrollees age 19 and older use the adult rates, including dependent children over the age of 18. For a family, each adult (including dependent children ages 21-26) are rated first, and then up to the three eldest children ages 0-20. You will not be charged premiums for more than three children between the age of 0-20, even if there are more children covered by the plan.

Note that the charts below provide pricing for many of the most common family units. For other combinations, please talk to your broker or sales representative.

Anthem Dental Family Value (monthly payments)

One child	\$16.77
One adult	\$12.72
One adult + one child	\$29.49
One adult + two children	\$46.26
One adult + three or more children	\$63.03
Two adults + one child	\$42.21
Two adults + two children	\$58.98
Two adults + three or more children	\$75.75

Anthem Dental Family (monthly payments)

One child	\$16.77
One adult	\$17.69
One adult + one child	\$34.46
One adult + two children	\$51.23
One adult + three or more children	\$68.00
Two adults + one child	\$52.15
Two adults + two children	\$68.92
Two adults + three or more children	\$85.69

Anthem Dental Family Enhanced (monthly payments)

One child	\$25.91
One adult	\$28.00
One adult + one child	\$53.91
One adult + two children	\$79.82
One adult + three or more children	\$105.73
Two adults + one child	\$81.91
Two adults + two children	\$107.82
Two adults + three or more children	\$133.73

Dental Prime (monthly payments)

	Plan A		Plan B		Plan C	
	Under age 65	Age 65 and over	Under age 65	Age 65 and over	Under age 65	Age 65 and over
Individual	\$25.10	\$26.10	\$42.40	\$45.35	\$52.70	\$60.05
Individual + one	\$48.80	\$50.75	\$82.45	\$88.20	\$102.45	\$116.75
Family	\$78.10	\$81.20	\$131.90	\$141.10	\$163.90	\$186.85

Blue View VisionSM (monthly payments)

This vision rider is available when purchased with any Anthem medical and/or dental plans.

Individual	\$6.64
Individual + one	\$11.62
Family	\$18.59



Rates apply to members under age 65 and are subject to change.

As of January 1, 2014, the Affordable Care Act (ACA) or health care reform law, requires health insurers to pay an annual fee to fund premium subsidies and Medicaid expansion. This fee applies to fully insured dental and vision plans. The monthly premiums listed above include the ACA insurer fee.

Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

Blue View Vision: Individual vision premiums for Colorado

For policies with effective dates of January 1 through December 31, 2019

We know you have choices when it comes to health care coverage. So why choose us for your vision plan? How about for convenience, choice and savings — right before your eyes!

With our stand-alone **Blue View VisionSM Enhanced**, **Blue View Vision Plus** and **Blue View Vision Value** plans, you'll get convenience and lots of choices. Our large provider network of more than 38,000 eye doctors at over 27,000 locations makes it easy to find a doctor or eye care retailer near your home or work.*

Blue View Vision monthly payments

Vision plan	Three-tier structure		
	Individual only	Individual + 1	Family
Blue View Vision Enhanced	\$16.96	\$29.68	\$47.48
Blue View Vision Plus	\$13.28	\$23.24	\$37.18
Blue View Vision Value	\$11.00	\$19.25	\$30.79

* Anthem internal data, 2016.

As of January 1, 2014, the Affordable Care Act (ACA) or health care reform law, requires health insurers to pay an annual fee to fund premium subsidies and Medicaid expansion. This fee applies to fully insured dental and vision plans. The monthly premiums listed above include the ACA insurer fee.

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Peace of mind made easy

**Anthem individual term life insurance —
affordable and no exam needed**



Life insurance is an important decision, but it doesn't have to be a complicated one.

You want your loved ones to be taken care of — even if you're not here to provide for them. That's why it's important to have life insurance to help your family with expenses when the unexpected happens. Anthem individual term life insurance plans can give your family peace of mind for their future. While you may not want to think about it, there's actually no better time than now to protect your family.

To make things even better, we've made it simpler to get coverage:

- There's no medical exam required.
- If you also have a health plan with us, you'll only get one bill for health and life coverage.
- Life insurance is available with Anthem's health coverage or without — it's your choice.

Our individual term life plans include two coverage options: \$25,000 and \$50,000.

You can choose the coverage amount that fits your needs. Individuals between the ages of 18 and 64 are eligible to apply.

Take a look at how much each plan would cost you:

Anthem individual term life monthly rates

Age	\$25,000	\$50,000
18	\$2.50	\$5.00
19-29	\$4.65	\$9.30
30-39	\$5.40	\$10.80
40-49	\$12.50	\$25.00
50-59	\$34.80	\$69.60
60-64	\$49.00	\$98.00

Want to know more?

Go to anthem.com for more information or to apply for life insurance. Or call 1-877-212-1793 with any questions.



The initial rates for term life insurance are based on your age at the time the policy is issued and are subject to change in accordance with the published rate table. The policy is issued for a one-year term, renewable at the policyholder's option. Term life insurance is subject to the written provisions of the policy. The policy contains exclusions and limitations, including the exclusion for death due to suicide for the first two years the policy is in force. The policy will terminate at age 65.

Life and Disability products underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

Copies of Colorado network access plans are available on request from member services or can be obtained by going to anthem.com/co/networkaccess. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

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Your prescription drug benefits

Anthem plans help keep you healthy and lower your health care costs

Your medications — covered

All of our pharmacy plans have a drug list that includes hundreds of covered brand-name and generic drugs in every category and class, meeting or exceeding Affordable Care Act (ACA) requirements. Individual and family plans use the Select Drug List.

To view the Select Drug List and see if your drug is covered, go to [anthem.com/pharmacyinformation](https://www.anthem.com/pharmacyinformation) and choose the Colorado **Individual Select Drug List**.

Filling your prescriptions

It's simple. Choose the way that works best for you to get the medicines you need, when you need them.

Home delivery pharmacy – your medicine delivered right to your door

We offer home delivery to make it easier for you to get your medicine quickly and safely. People who use home delivery pharmacy are more likely to follow their drug treatment plan, resulting in increased medication adherence. That means fewer doctor visits and hospital stays — and lower health care costs for you.¹

Retail pharmacies in your network

The **Rx Choice Tiered Network** offers two levels of pharmacies — giving you choices, convenience and savings:

Level 1	Get the lowest cost for your prescriptions when you use one of nearly 25,000 Level 1 network pharmacies, including CVS, Target, Wal-Mart, Kroger and Costco .
Level 2	You can also use one of the 45,000+ Level 2 network pharmacies. Your prescriptions will be covered, but you'll pay an additional copay or coinsurance.

Our **National Pharmacy Network** includes nearly 70,000 retail pharmacies — making it easy for you to get prescriptions filled near your home or work, or even when you travel.





Your pharmacy benefits — easy to manage at [anthem.com](https://www.anthem.com)

Manage all your prescription benefits in one place. It's easy. It's convenient. And you can do things like:

- Find out if your drug is covered. Go to [anthem.com/pharmacyinformation](https://www.anthem.com/pharmacyinformation) and choose the **Individual Select Drug List** for your state.
- See if your preferred pharmacy is in the plan's network.
Visit [anthem.com/pharmacyinformation/rxnetworks.html](https://www.anthem.com/pharmacyinformation/rxnetworks.html) to see all of the pharmacies in our networks, including Level 1 pharmacies where you can save the most money.
- Learn more about your pharmacy benefits — including why some drugs need preapproval to be covered — by going to our frequently asked questions (FAQs) at [anthem.com/faqs/colorado/pharmacy](https://www.anthem.com/faqs/colorado/pharmacy).

On the go, too! Most of the same helpful tools are available on your cell phone or other mobile device with the Anthem Anywhere app. You can manage your drug benefits wherever you are, whenever you need to.

Medical + pharmacy — better and easier than ever

With our combined medical and pharmacy benefits, your doctor can see the whole picture of your health.

For you, this means:

- Better overall health.
- A smoother experience.
- Fewer hospital stays and lower medical costs.²
- Saving more on prescription drugs.²

¹ Examination of the Link Between Medication Adherence and Use of Mail-Order Pharmacies in Chronic Disease States. Journal of Managed Care & Specialty Pharmacy, Nov. 2016.

² Integrating pharmacy with medical benefits can help your bottom line. Smart Business Online (sbonline.com), Apr. 2015.

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the <enter contract name> may be continued in force or discontinued. For more information, review the <enter contract name>, call your Anthem Sales representative or go to [anthem.com](https://www.anthem.com).