Individual and family health benefit plans for Colorado

We make it easy

Looking for a new health plan? We can help.

Anthem BlueCross BlueShield

CONNECT for HEALTH COLORADO™

Bronze, Silver and Gold plans
Certified by Connect for Health Colorado™

Health care on your terms

When it comes to individual health care coverage, it's not one-size-fits-all. Anthem Blue Cross and Blue Shield (Anthem), through its subsidiary company, HMO Colorado, offers you a range of options so you can compare plans and find the best coverage for your need and budget. No one knows what you and your family needs better than you. Just let us know and we're here to help when and where you need us.

Take control of your health

When you choose Anthem, you don't just get a health plan. You get a total health coverage solution that can help you live healthier and feel your best, while saving money along the way. With Anthem, you get:

- $0 cost preventive care[1] (like checkups and flu shots) with no deductible or copay when you see in-network providers
- Guaranteed coverage, no matter what your health
- Prescription drug benefits at local and nationally recognized pharmacies, plus a mobile app to help you find a pharmacy, order a refill, check order status and more
- 24/7 NurseLine so you can speak to a nurse any time of the day or night and online support whenever you have questions
- The Away From Home Care or Guest Membership program that allows approved covered dependents temporarily living away from home to become guests on an affiliated Blue Cross and Blue Shield HMO plan in the area where they're staying
- Care support programs to help you take care of chronic or complex health problems
- No lifetime dollar maximums on covered services
- Easy-to-use tools to find a doctor, hospital or pharmacy

Health plans don't have to be hard to figure out. See how easy it can be with Anthem.

- ***Personalized help.*** If you're trying to decide which plan will work best, we've got answers for you.
- ***Access to quality care.*** Make sure you're getting the quality health insurance you want. Make sure you get Anthem.
- ***Reliable customer service.*** Our associates are dedicated to giving you the help you need, when you need it.
- ***Simple.*** Health care coverage isn't always easy to understand. We'll help you make sense of it.
- ***Stable.*** One thing is clear about the changes in health care coverage – you can count on us to be there for you.

Call your broker or Anthem authorized representative or visit us online at anthem.com where you can view and compare plan options.

Access the benefits that matter to you

All of our plan options have one major goal in mind: To help you stay healthy and find the quality coverage you need when you need it. That's why, no matter which plan you choose, you're covered from preventive care to emergencies, and more!

What's covered?

- In-network preventive care services, including screenings, and help managing a chronic (ongoing) disease
- Outpatient services
- Emergency services, like going to the emergency room (ER) or urgent care center (when necessary)
- Inpatient services (care received when you stay overnight in a hospital)
- Laboratory services (blood work, screenings)
- Prescription drugs
- Rehabilitative and habilitative services (habilitative services help a person learn, keep or improve skills they may not be developing normally)
- Mental health and substance abuse services
- Maternity (pregnancy) and newborn care
- Pediatric services (health care for children)
- Durable medical equipment (Durable medical equipment or DME includes medical equipment and supplies for things like hospital beds, crutches, wheelchairs and oxygen tanks)

Take a closer look at prescription drug coverage

Prescription drug benefits help cover the cost of medications your doctor prescribes. We're here to help you better understand how our prescription drug plans work and the choices you have when it comes to selecting and paying for these medications. Always talk to your doctor first about which medication is right for you.

Select drug list (Drug formulary)

All of our prescription drug plans have a formulary, called the Select Drug List. The Select Drug List is not a complete list, but is simply a list of the most commonly used FDA-approved drugs that your plan covers.

Prescription drug tiers

Every drug on the Select Drug List is assigned to a certain tier (or level) based on cost, availability of over-the-counter alternatives, clinical information and certain drugs used to treat the same or similar condition. The drug list tells you what tier your drug is in and related details on coverage. What you pay for your prescription depends, in part, on which tier your drug is in. For example, Tier 1 usually includes preferred generic drugs with the lowest cost to you. As the tier number increases, the drugs in that tier generally cost you more. If your drug is in a higher tier, you may want to speak with your doctor to find out if one of the drugs covered in a lower tier will work for you.

You can save even more money with home delivery pharmacy

Anthem wants to help lower the cost of prescription drugs, improve overall health and deliver top-notch customer service. We're here to help you understand and manage medicines used to treat a wide variety of conditions.

With our plans, you'll use the home delivery pharmacy, managed by Express Scripts, Inc., instead of a retail pharmacy, for drugs you take on a regular basis (e.g. maintenance medicines). These drugs are used for conditions like high blood pressure and high cholesterol. If you are taking a maintenance medication, you may get the first 30-day supply, plus one additional 30-day refill of the same maintenance medication, at your local retail pharmacy. You must then use the home delivery pharmacy.

Home delivery is convenient and safe

- You get up to a 90-day supply for non-specialty drugs
- Drugs are delivered straight to your door — with free standard shipping
- You can order refills your way – online, using our mobile app, by phone or by mail
- Many safety and high-level quality checks help make sure you get the right medicine in the right dose

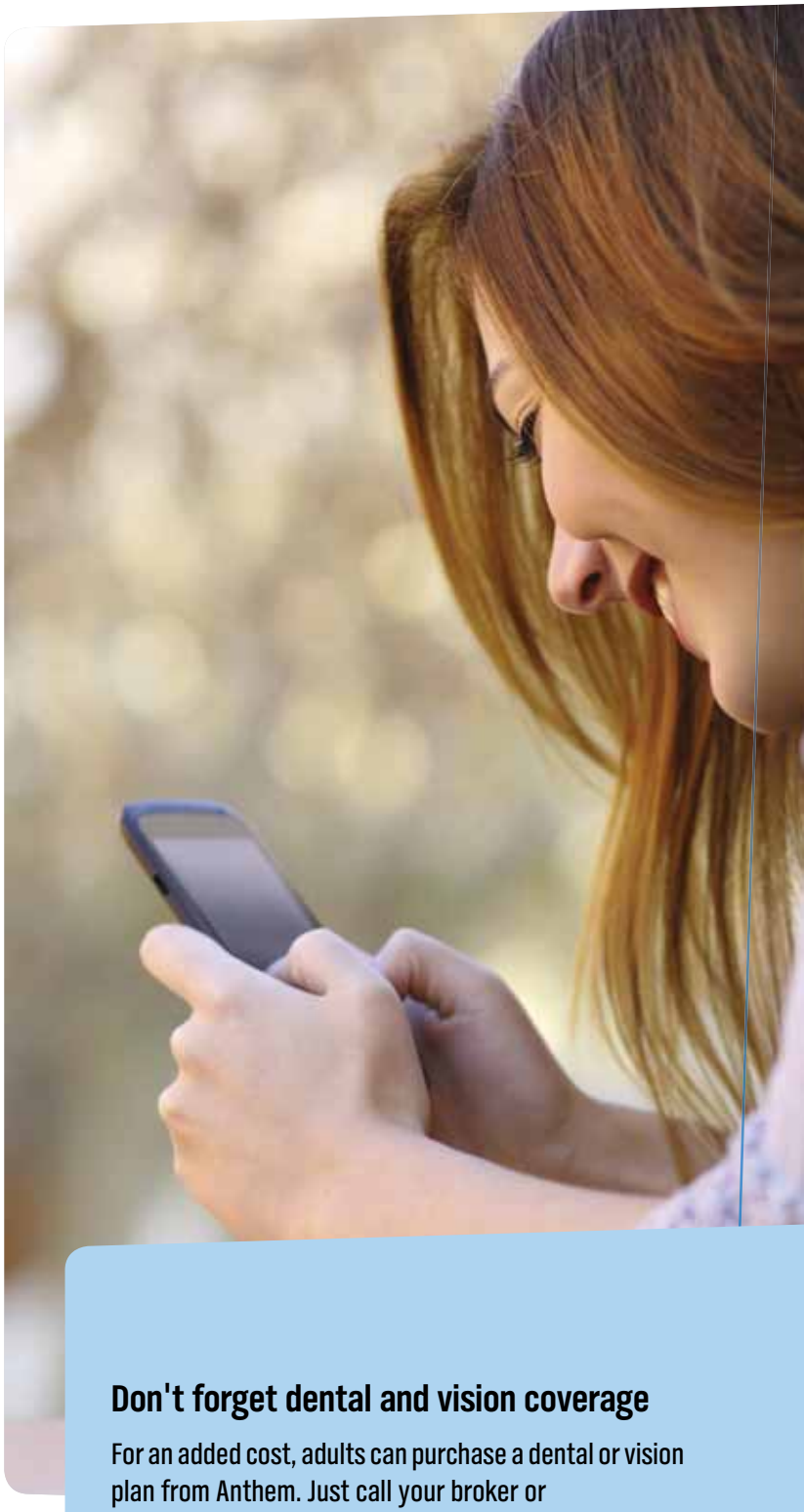
Manage your prescription drug benefits from your smartphone

Just by going to your health plan's mobile app, you can easily take advantage of our handy pharmacy tools on the go. With the click of a button you can:

- Locate a pharmacy
- Price a medication
- Switch from retail to home delivery
- Order a refill
- Check order status
- And more!

For more information, go to anthem.com:

- To find out if your medication is covered, take a look at our drug list at www.anthem.com/COSelectdrugtier4.
- To learn more about pharmacy processes (such as prior authorization, step therapy, quantity limits, dose optimization), check out the FAQs at Customer Support > FAQs > FAQ Categories > Pharmacy.
- To see if your pharmacy is in our network, visit our Find a Doctor tool.



Don't forget dental and vision coverage

For an added cost, adults can purchase a dental or vision plan from Anthem. Just call your broker or Anthem authorized representative or go online to anthem.com for details.

See a term you're not familiar with? Check out our Glossary in the back of this brochure.

Choose the doctors and hospitals you know and trust

At Anthem, our goal is to work with doctors, hospitals and other health care providers who will give you quality care at a fair cost. Our Pathway X and Mountain Enhanced X networks include:

- Doctors and hospitals
- Emergency and urgent care centers
- Labs
- Durable medical equipment providers (includes retail and online stores)
- Mental health providers

Mountain Enhanced X Network is available in the following communities only: La Plata county (Durango),Montezuma county (Cortez), Summit county (Keystone/Frisco/Breckenridge) and Eagle county (Vail Valley).

Take care of yourself with no-cost in-network preventive care

Anthem's preventive care coverage options give you access to any of our in-network doctors, so you pay nothing out of pocket. Stay in control of your health care and your finances with $0 deductible, $0 copay and $0 added cost to you for covered preventive services received in our network.[1]

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

Stay in control of quality and costs with our easy-to-use online tools

Anthem offers a range of ways to get the information you need. From our website to cost and quality comparison tools to our mobile app that lets you find a doctor from the palm of your hand, we help make sure you have everything you need to make the best health care decisions for you and your family. With our website, you can:

- Get an idea of what is and isn't covered by your plan with an easy-to-understand breakdown of your benefits summary.
- Get instant access to your recent claims and coverage details.
- Know your costs before having certain procedures with cost estimates using our out-of-pocket cost calculator.

Find a Doctor

Want to make sure your doctor is in our network? Need to find a new doctor or specialist? No problem! Our online Find a Doctor tool helps you find doctors, hospitals, pharmacies and other specialists in your area — and shows whether they are cost-saving network providers.

Log on to anthem.com anytime or download our mobile app right to your phone, so you can search for doctors when you're on the go. When using the Find a Doctor tool, be sure to include the plan network (Pathway X or Mountain Enhanced X) as search criteria for the plan you are considering.

Vitals health survey

Vitals makes it easy for you to see what other patients have said about the doctors and hospitals you may be thinking about using. Hearing what other patients' experiences were like can help you make more informed health care decisions about your own care. You can also share your experience with others by reviewing your doctor online!

Cost and quality information with Estimate Your Cost

Save time and money by comparing the cost of common procedures at health care facilities in your area. You'll also get to compare quality and safety.

SpecialOffers discounts on health-related products and services

Enjoy members-only discounts on vitamins, health and beauty products, chiropractic care, acupuncture, massage therapy, LASIK eye surgery, eyeglass frames and contact lenses, hearing aids and services, fitness center memberships, Jenny Craig® and Weight Watchers® weight-loss programs and more. To view all discounts, log in at anthem.com and click on Discounts located on the Main Overview page.

Register at anthem.com for online access

Once you're a member, you'll want to register to get online access to your benefits. It's the information you need to make an informed decision – all in one place.

To register, type anthem.com in the web browser address field and click **Register Now** on the top right-hand side of your screen in the member log in area.

Don't miss out on these great tools! Be sure to register at anthem.com.

Take charge of your health with our health and wellness programs

Your health goals and needs are as unique as you are. That's why Anthem gives you access to programs that help you meet your personal goals and live your life to the fullest.

Get help from nurses 24/7

Day or night, you can talk to a registered nurse about your health concerns. Whether it's a question about allergies, the flu or choosing between the ER or urgent care, our nurses are there to give support. Going to the right place when you're not feeling well can save you time and money.

Supporting you when you have a larger health problem

Your health is our top priority. If you have a chronic or complex health problem, our Care Management Support program may be able to help. A case manager may call you to see how we can help you manage your health concerns. Our case managers can provide you with helpful information and offer emotional support services, if needed.

MyHealth Advantage

We're always looking for ways to help you live a healthier life and save money. That's why we review your medical and pharmacy history. If we find a way we think you can improve your health or save money, you'll get a MyHealth Note in the mail.

Coverage for emergency and urgent care — no matter where you are in the U.S. — with BlueCard®

When you're traveling for work or on vacation, going to the ER or urgent care is probably the last thing you want to happen. The good news is our plans cover emergency and urgent care in every state through the Blue Cross and Blue Shield Association's BlueCard® Program. This means you and your family have emergency and urgent care coverage from coast to coast.

Find the plan that's right for you

Choosing the right health care coverage is an important decision. Before you choose a plan, consider these tips. And remember, your broker or Anthem authorized representative is here to answer any questions.

Plan ahead

- **Make sure the plan will meet your health care coverage needs**. Think about how often you see doctors and specialists. What prescription medications do you take regularly?
- **If staying with your current doctors is important**, see if they're in our network by using our online Find a Doctor tool at anthem.com. Seeing in-network doctors can save you a lot of money on your health care.
- **Figure out your family's budget for coverage**. Some people would prefer to pay more in premium each month and less out of pocket each time for services like doctors' visits or lab work. Plans may offer different deductible, coinsurance and copay options so you can choose the level of cost sharing that meets your health care coverage needs and budget.
- **Review your plan options.** We offer plans to fit your health care coverage needs — and your budget. They are split into three different levels — Bronze, Silver and Gold. Your costs and coverage increase with each level.
  - *Bronze* - With a Bronze plan, you pay less for your monthly premium but you pay more when you get care. You have broad benefits with deductibles, copays and coinsurance that may be higher than the other plans.
  - *Silver* - Silver plans still have low monthly premiums but you pay less when you get care. However, the monthly premium is higher than the Bronze plan. An additional cost-sharing subsidy may be available to you on this plan level if you qualify.[2] That means you may be able to get a plan with a lower deductible or copay.
  - *Gold* - With a Gold plan, you have richer benefits and pay less when you get care. However, the monthly premium is higher than the Bronze and Silver plans.
- **Consider making contributions to a Health Savings Account (HSA).** Making post-tax contributions to an HSA can help make your money go further. An HSA is a savings account that you can open when you have a qualified high deductible health plan (HDHP). You set up the account through a bank and fund it with post tax dollars. That money can be used to pay for your qualified health care expenses, including prescriptions. Talk to your financial advisor about potential tax advantages.

Explore your options if you need help paying for coverage

The Affordable Care Act requires you to have health care coverage unless you qualify for an exemption. In addition, you may qualify for premium tax credits to help lower the cost of your monthly premium. You may also qualify for cost-sharing subsidies on Silver plans purchased on the Exchange, which can reduce the amount you pay for health care services. Or you may be eligible for your state's Medicaid program. The amount and type of financial help you could receive is based on your income, family size and health care expenses where you live.

Here are a couple of points to keep in mind about help:

- **See if you qualify for a tax credit or subsidy.** You might be able to get a tax credit that can be used toward any plan purchased on Connect for Health Colorado if your income is 133% to 400% of the federal poverty level. If your income is 250% of the federal poverty level, an additional cost-sharing subsidy may be available to you for Silver Exchange plans only.

- **Subsidies can make Silver plans ineligible for an HSA.** If you qualify for a subsidy on the Exchange, you may not be able to enroll in a Health Savings Account (HSA). Since cost-sharing subsidies actually lower your deductible and out-of-pocket costs, sometimes a subsidy can lower these amounts enough to drop them below the federal government's minimum deductible threshold for HSA eligibility. And if that happens, you would become ineligible for the HSA feature but automatically enrolled in the base plan without the HSA component.

- **Connect for Health Colorado is just one way you can shop for health coverage.** You can still get coverage directly from an insurance company, like Anthem. However, if you want to apply for a subsidy, you will have to buy coverage through Connect for Health Colorado.

Call your broker or Anthem authorized representative or go to anthem.com to learn more about exchanges and subsidies.

When you can purchase a plan

Generally, plans can be purchased once a year through an open enrollment period. This year, the open enrollment period runs November 15, 2014 through February 15, 2015. The annual open enrollment period may vary from year to year, so you should check with your broker or Anthem authorized representative for more information.

Not sure what something means? See the Glossary in the back of this brochure.

When certain events occur in life, you can enroll in a plan

There are a lot of life events — from having a baby to moving to a new state — that may allow you to change your health plan during a **special enrollment period**. These are called "qualifying events." If you've had a change in your coverage, family or income that qualifies, you can shop for a new health plan without waiting for the next open enrollment period.
Let us know if you're:

- Losing coverage at work
- Getting married or divorced
- Having a baby or adopting a child
- Turning 26 and no longer covered under your parents' plan
- Experiencing other changes in your coverage, family or income
- Moving soon or just moved

Don't wait too long. Most people have only 60 calendar days after a qualifying event to enroll in a new plan. You'll need to show proof of the qualifying event.

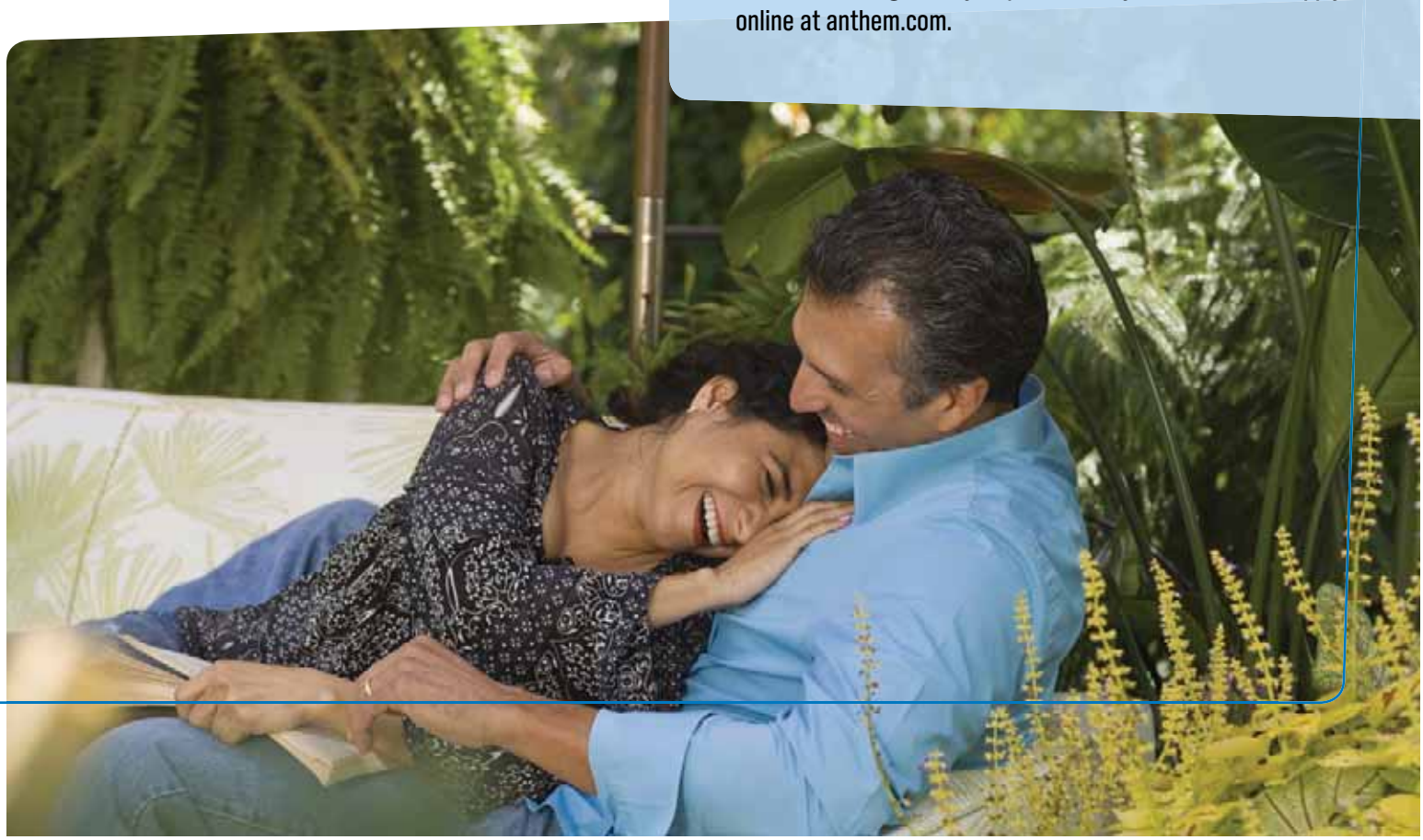
Check with your broker or Anthem authorized representative for effective date options and guidelines around enrollment during other times of the year.

Avoid tax penalties

When you put off enrolling in a health plan, you may have to pay a penalty unless you qualify for an exemption. Penalties are based on your pay and increase each year. So, for example, by 2016 the penalty for a family of four with a household income of $70,000 could be as much as $1,750. And the penalty amounts will continue to go up in the future.

Ready to enroll in a plan? We can help!

Your broker or Anthem authorized representative is available to make enrolling as easy as possible for you. You can also apply online at anthem.com.



Follow these easy steps to enroll in one of our health plans

You and your family can receive all of the benefits of the Affordable Care Act. All you have to do is enroll. You may have heard it's hard to do, but it's really not and we're here to help you every step of the way.

What you'll need

Before you begin the enrollment process, be sure to have these handy:

- Employer and income information for every member of your household who needs coverage (for example, pay stubs or W-2 forms)
- Policy numbers and insurer names for any current health insurance plans covering members of your household
- Information about every job-based health insurance plan for which you or someone in your household is eligible

How to enroll in one of our Anthem plans

- Call your broker or Anthem authorized representative to enroll or learn more about the health care plans offered by Anthem.
- Visit our website at anthem.com and apply online.
- Find our plans on Connect for Health Colorado at www.ConnectforHealthCO.com.

Save money by making smart choices

- ***Save money on prescriptions with home delivery -*** When you use our home delivery pharmacy instead of a retail pharmacy, you'll save on drugs you take on a regular basis for a long time (e.g., maintenance medicines). These drugs are used for conditions like high blood pressure and high cholesterol. You can usually get a 90-day supply of non-specialty drugs for less than you would at a retail pharmacy, and standard shipping is free.

- ***Save time and money with an urgent care center or retail health clinic*** - You may save money - and usually lots of time - by going to places other than the emergency room (ER) when you need care for something other than an emergency. If you need care - and you're certain it's not a real emergency - the Find a Doctor tool at anthem.com can help find care alternatives to the ER like, urgent care centers, walk-in doctors' offices and retail health clinics.

- ***Using in-network doctors can help you save -*** When you need care, you will get the best value by visiting **in-network** doctors, hospitals or other health care providers. **In-network** (or participating) refers to doctors, hospitals and other health care providers that have agreed to accept lower negotiated rates (discounted prices) for their covered services. These agreed upon rates can help lower the cost of covered health care services, including your share of the costs. This is true when you're paying the whole cost for covered services (such as while you are meeting your deductible). And it's also true when we are sharing the cost (while you are meeting your out-of-pocket limit).

  Out-of-network (or nonparticipating) refers to doctors, hospitals and other health care providers that are not contracted with Anthem to provide services at a negotiated rate. **Our plans do not offer out-of-network benefits (with the exception of emergency and urgent care or when we authorize care)**. This means you will pay the entire cost for any service you get from **out-of-network** providers.

  To find out if your current health care provider is in our network, visit our Find a Doctor tool on anthem.com.

- ***The doctors you can see -*** When you choose one of our health plans, you pick a primary care physician (PCP). Having a primary physician you see anytime you need a checkup or a health issue is a good idea. You have a choice of in-network PCPs. **When you need to see other doctors, a referral from your PCP is not required.**

- ***Guest Membership/Away From Home Care when temporarily living out of state -*** With our *health maintenance organization (HMO) plans*, you or any of your covered dependents who will be away from home (and outside of your health plan's service area) for more than 90 days, can apply 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 will allow you to become a "guest" of that other plan and take advantage of the benefits and coverage it provides. Guest membership comes in handy when students go to college in another state. Guest membership is not available in all areas.

- ***SpecialOffers discounts on health-related products and services -*** When you're a member, you can save money on all kinds of products and services that can help you live a healthy life. To view all discounts, log in at anthem.com and click on Discounts located on the Main Overview page.

- ***Make your health care dollars work harder with a Health Savings Account -*** A Health Savings Account (HSA) is a savings account that you can open when you have a qualified high deductible health plan (HDHP). You set up the account through a bank and fund it with post-tax dollars. That money can be used to pay for your qualified health care expenses, including prescriptions. HSA-compatible health care plans work with or without this savings account, the choice is yours. Plan choices that are HSA-compatible include HSA in the plan name. Check with your tax advisor to see if an HSA plan is right for you and check out the insert from our preferred banking partner, BenefitWalletTM.

Not sure what something means? See the Glossary in the back of this brochure.

Helping you understand how your health care plan works

Health care coverage can help protect you against the high costs of care. With most health care coverage, you pay a monthly fee called a premium; then, you share some of the cost of covered care with the company that provides your coverage. With Anthem, you can choose the level of cost sharing that works best for your health care needs and budget.

Here's an example: *Meet John*

John's story is only an example of how health plans work. John is not a real person and the example below is for illustrative purposes only. Be sure to look at the benefits for each of our plan choices for specific information.

John's health plan has the following benefits:

- $35 copay for doctor visits - $2,000 deductible - 30% coinsurance - $5,000 out-of-pocket limit

After injuring his knee in a soccer game, John calls his doctor. He chooses providers in our network, which saves him the most money. By choosing providers in our network, John gets lower negotiated rates (meaning, discounted prices). In the following examples, you'll see what John paid and why it's important to have health insurance.

Copay (Copayment)

On some plans you pay a fixed dollar amount for certain services when you get them. For example, when you see a doctor, you may be asked to pay a $35 copay.

Let's take a closer look at John's doctor's visit copay:

- ***Doctor visit cost (without insurance):*** $200
- Anthem's ***negotiated rate:*** $140
- Anthem ***pays:*** $105
- *What John paid:* $35 (his plan's copay for doctor office visit)

Deductible

You pay this amount for covered medical services each calendar year which means January 1 through December 31. Covered services that apply to the deductible may include lab work, X-rays, anesthesia and surgeon fees. (Covered preventive services start before the deductible is met.) Your deductible starts over each calendar year.

Please note:
For non-HSA plans, each family member has an individual deductible and out-of-pocket limit. The family deductible and out-of-pocket limit can be satisfied by two or more members. No one person can contribute more than his or her individual deductible or out-of-pocket limit. For HSA-compatible plans, either one or more family members must meet the family deductible before any covered services that are subject to the deductible will be paid by the plan. The family out-of-pocket limit can be met by either one or more members. Once the limit is met, no additional coinsurance will be required for the family for the remainder of the calendar year.

Here's what happens next when John's doctor orders an approved MRI of the knee and recommends surgery:

MRI

- ***MRI cost (without insurance):*** $1,500
- Anthem's ***negotiated rate:*** $1,000
- *What John paid:* $1,000 (John's payment counts toward his plan's $2,000 deductible.)

Surgery

- ***Hospital/surgery costs (without insurance):*** $50,000
- Anthem's ***negotiated rate:*** $35,000
- *What John paid:* $1,000 (John's payment satisfies the remaining $1,000 deductible.)
- ***Remaining cost of surgery:*** $34,000

Coinsurance

Once you've met your deductible, Anthem starts paying a portion of claims. The health care bills that remain are shared between you and Anthem. Your coinsurance is the percent that you must pay for a covered service per calendar year. Having met his deductible, John's coinsurance begins.

Let's check in to see what John will be paying.

- ***Coinsurance:*** 30% (30% of $34,000 = $10,200)
- *What John paid:* $2,965 (John's payment satisfies the remainder of his $5,000 out-of-pocket limit.)

Out-of-pocket limit

The most you pay during a policy period before your health insurance begins to pay at 100% (of the maximum allowed amount). The amounts you pay for your deductible, coinsurance and copay are typically what make up your out-of-pocket limit. Once you meet your out-of-pocket limit, we pay 100% (of the maximum allowed amount) of covered services for the rest of the calendar year.

John has met his out-of-pocket limit and the remaining surgery costs are paid by Anthem.

- Anthem ***pays:*** $31,035
- ***Out-of-pocket limit:*** $5,000 (John paid: $35 copay for doctor office visit + $2,000 deductible + $2,965 coinsurance)

Summary

John paid far less out-of-pocket because he had health care coverage. If John had used a provider outside of our network, depending on his plan, he might not have had coverage or would have had to pay much more.

- ***Total for doctor visit, MRI and surgery (without health insurance):*** $51,700
- ***Total*** Anthem ***paid after discounts:*** $31,140
- *Total John paid:* $5,000

Glossary

Affordable Care Act (also known as health care reform)
The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

BlueCard
BlueCard is a national program that lets members of one Blue Cross and Blue Shield (BCBS) plan access health care services while traveling in another BCBS plan's service area. Available services may be limited with these plans. To find doctors and hospital in the BlueCard program, have your ID card handy and visit the BlueCard Doctor and Hospital Finder at bcbs.com.

Brand-name drugs
These are drugs that are developed by a company that holds the patents and rights to sell them.

Coinsurance
The amount that you pay for health care services. This is usually a certain percentage of the cost of health care services after the deductible has been paid. *Example*: A health plan pays 80% of the maximum allowed amount for the service and you pay the remaining 20%. This is referred to as the coinsurance.

Copay (also copayment)
A fixed fee that you pay out-of-pocket for each visit to a health care provider. For example, if your copayment is $30, then you pay $30 when you see your doctor — usually at the time you receive treatment. The amount of your copayment sometimes varies by the type of health care service you receive.

Deductible
This is a set amount that you pay before your plan starts paying for covered services. For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. Note: You must meet your deductible every calendar year even if your effective date (the date your coverage begins) is later than January 1. The calendar year runs from January 1 through December 31.

Exchange (also known as the Marketplace)
A resource where individuals, families, and small businesses can: learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan and enroll in coverage. The name of the Exchange in your state is Connect for Health Colorado.

Exclusions
Exclusions are health care goods and services that are not covered by your health plan. You can find a list of exclusions in your plan materials.

Formulary (also Select Drug List)
This is a list of the most commonly used drugs your plan covers. The list tells you what tier your drug is in and related details on coverage.

Generic drugs
Generics are copies of brand-name drugs with the same active ingredients. Most generics usually cost you less money than their brand-name counterparts.

Health Savings Account (HSA)
A HSA is a savings account that you can open when you have a qualified high deductible health plan (HDHP). You set up the account through a bank and fund it with post tax dollars. That money can be used to pay for your qualified health care expenses, including prescriptions.

High-deductible health plan (HDHP)
A HDHP has lower premiums and higher deductibles than a traditional health plan.

In-network/Network
Refers to providers who participate in the plan's network.

Out-of-network/Non-network
Refers to providers who do not participate in the plan's network.

Out-of-pocket limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the maximum allowed amount. This limit never includes your premium, balance-billed charges, or health care your insurance or plan doesn't cover.

Premium
The amount that must be paid for your health insurance or plan. You usually pay it monthly, quarterly or yearly.

Premium tax credit
A fixed amount or percentage of a member's premium provided as a tax credit to help low-income individuals buy health insurance on the Exchange. You can use it to buy any plan offered on the Exchange in your state.

Prescription drug tiers
Every drug on the formulary (Select Drug List) is in a cost-sharing tier. The tier level determines what you will pay for your prescription.

Primary Care Physicians (PCPs)
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Provider
A doctor, hospital, licensed health care facility, program, agency or health care professional that delivers health care services.

Learn more

You've read about a lot in this brochure. If you'd like to learn even more, here is a list of helpful resources:

- ***Health care reform hub***
  makinghealthcarereformwork.com (visit anthem.com > Resources > select Health Care Reform)
- ***Subsidy Estimator***
  kff.org/interactive/subsidy-calculator/
- ***www.ConnectforHealthCO.com***
- ***Will I qualify to save on monthly premiums?***
  www.healthcare.gov/will-i-qualify-to-save-on-monthly-premiums/
- ***Injury Facts 2011 Edition***, National Safety Council
  nsc.org/news_resources/injury_and_death_statistics/Documents/Injury-Facts-Report.pdf
- ***The Unsustainable Cost of Health Care***
  Social Security Advisory Board ssab.gov/Documents/Summary-HealthCare.pdf
- ***The Henry J. Kaiser Family Foundation***
  statehealthfacts.org
- ***National Hospital Discharge Survey***
  Centers for Disease Control and Prevention
  cdc.gov/nchs/nhds.htm
- ***Costhelper***
  health.costhelper.com/broken-leg.html

Anthem BlueCross BlueShield

Get help today!

Call your broker or Anthem authorized representative or visit us online at anthem.com where you can view and compare plan options.

Anthem Blue Cross and Blue Shield, through its subsidiary company, HMO Colorado, is pleased to offer individual health plans through Connect for Health Colorado. Learn more about Connect for Health Colorado and financial assistance at www.ConnectforHealthCO.com.

We want you to be satisfied

After you enroll in a plan offered by Anthem, you'll receive a Evidence of Coverage (EOC or Booklet) that explains the exact terms and conditions of coverage, including the Booklet's exclusions and limitations. You will have 10 days to examine your Booklet's features. During that time, if you are not fully satisfied, you may cancel your Booklet and your premium will be refunded, less any claims that were already paid.

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

- Review the Booklet.
- Call your broker or Anthem authorized 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 www.sbc.anthem.com > Select Member.

In accordance with the Affordable Care Act, benefits, formularies, pharmacy and provider networks, premiums and copayments/coinsurance for these plans may change on January 1 of each year.

1. Nationally recommended preventive care services received from in-network providers have no copay and no deductible requirement. Preventive and wellness services consist of certain services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.
2. Subsidies are only available for Qualified Health Plans purchased through Connect for Health Colorado. HMO Colorado, dba Anthem Blue Cross and Blue Shield, is a Qualified Health Plan issuer that offers such plans through Connect for Health Colorado.

SpecialOffers is a service mark of Anthem Insurance Companies, Inc. Vendors and offers are subject to change without notice. Anthem does not endorse and is not responsible for the products, services or information provided by the SpecialOffers vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members. All other marks are the property of their respective owners. All of the offers in the SpecialOffers program are continually being evaluated and expanded so the offerings may change. Any additions or changes will be communicated on our website, anthem.com. These arrangements have been made to add value for our members. Value-added products and services are not covered by your health plan benefit. Available discount percentages may change or be discontinued from time to time without notice. Discount is applicable to the items referenced.

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. BenefitWallet is an independent corporate entity that provides banking administration on behalf of Anthem Blue Cross and Blue Shield.

Individual and family health benefit plans for Colorado

Benefit Snapshot

Bronze, Silver and Gold plans certified by Connect for Health Colorado™

Anthem BlueCross BlueShield

CONNECT for HEALTH COLORADO™

Benefit Snapshot

Anthem Blue Cross and Blue Shield (Anthem), through its subsidiary company, HMO Colorado, is pleased to offer individual plan choices. Below is a listing of them, including a sample of commonly used benefits and how they are covered under each plan. ***Cost-share and benefit information in this snapshot is for in-network covered services unless otherwise noted.*** When filling out an application, be sure the entire plan name on the application matches the plan you're applying for.

Our plan names include the following elements: Anthem + metal level + network name + product type + deductible/coinsurance + (for HSA) (Example: Anthem Bronze Pathway X HMO 5000/40%). Elements in parenthesis are used when appropriate. If you need more information about a benefit that is not listed here, please check with your broker or Anthem authorized representative. You can also view and compare plans on anthem.com.

	Anthem Bronze Pathway X HMO 5000/40%	Anthem Bronze Mountain Enhanced X HMO 5000/40%†	Anthem Bronze Pathway X HMO 5750/30%	Anthem Bronze Pathway X HMO 6250/20%
Network Name[1]	Pathway X	Mountain Enhanced X	Pathway X	Pathway X
Individual Deductible *(Family[2] = 2 x Individual amount)*	$5,000	$5,000	$5,750	$6,250
Individual Out-of-pocket Limit *(includes deductible, copays, coinsurance and pharmacy. Family = 2 x Individual amount)*	$6,600	$6,600	$6,600	$6,600
Coinsurance	40% coinsurance	40% coinsurance	30% coinsurance	20% coinsurance
Office Visit: Primary Care Physician *(PCP)* *(includes post natal visits)* Note: Other office services subject to deductible and plan coinsurance	$50 copay per visit for first 2 office visits, then deductible and 40% coinsurance	$50 copay per visit for first 2 office visits, then deductible and 40% coinsurance	$45 copay per visit for first 2 office visits, then deductible and 30% coinsurance	$40 copay per office visit, unlimited
Office Visit: Specialist	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Outpatient Diagnostic *(Examples: X-ray, EKG)* and Outpatient Advanced Diagnostic Tests *(Examples: MRI, CT scan)*	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Preventive Care[3]	No additional cost to you	No additional cost to you	No additional cost to you	No additional cost to you
Urgent Care	Deductible, then $50 copay and 40% coinsurance	Deductible, then $50 copay and 40% coinsurance	Deductible, then $50 copay and 30% coinsurance	Deductible, then $50 copay and 20% coinsurance
Emergency Room Care	Deductible, then $200 copay and 40% coinsurance	Deductible, then $200 copay and 40% coinsurance	Deductible, then $200 copay and 30% coinsurance	Deductible, then $250 copay and 20% coinsurance
Hospital: Inpatient Admission *(e.g. hospital room)(includes maternity, mental health and substance abuse)*	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then 20% coinsurance
Hospital: Outpatient Surgery Hospital Facility	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Maternity *(includes delivery and all inpatient services)*	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then 20% coinsurance
Retail Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible	Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible
Retail Pharmacy Tier 1[4,5]	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	$20 copay
Retail Pharmacy Tier 2[4,5]	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	$50 copay
Retail Pharmacy Tier 3[4,5]	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Retail Pharmacy Tier 4[4,5]	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Dental[6,7]	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered
Vision	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered
Mental Health and Substance Abuse: Outpatient Facility & Services	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Physical, Occupational and Speech Therapy[8]	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance

More about our plans...

†**Mountain Enhanced X** Network is available in the following communities only: La Plata county (Durango),Montezuma county (Cortez), Summit county (Keystone/Frisco/Breckenridge) and Eagle county (Vail Valley).

[1]Our **Pathway X** and **Mountain Enhanced X** plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with these HMO plans.

[2]Our plans, with the exception of HSA plans, have **embedded family deductibles** where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits. Our HSA plans have **non-embedded family deductibles** where all family members share one common family deductible.

[3]Nationally recommended **preventive care services** received from in-network providers have no copay and no deductible requirement. **Preventive care services** consist of certain services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

[4]**Prescription drugs:** You'll use the home delivery pharmacy, managed by Express Scripts, Inc., instead of a retail pharmacy, for drugs you take on a regular basis (e.g. maintenance medicines). If you are taking a maintenance medication, you may get the first 30-day supply, plus one additional 30-day refill of the same maintenance medication, at your local retail pharmacy. You must then use the home delivery pharmacy.

[5]**Prescription drugs:** Covered medications are assigned to certain tiers (or levels) based on cost, availability and similar alternatives. Our plans have multiple tiers. Tier 1 medications may have a lower cost share for the member.

[6]**Pediatric dental** is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

[7]The **pediatric dental** policy DOES NOT provide any dental benefits to individuals age nineteen (19) or older. The pediatric dental policy is offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. A person age nineteen (19) or older will need to buy a separate adult plan if they want adult dental benefits. The pediatric dental policy WILL NOT pay for any adult dental care.

[8]**Physical, occupational or speech 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.

- You may qualify for a tax credit subsidy or cost share reduction on Silver plans. Check with your broker or Anthem authorized representative for more information and to find out if you qualify for a tax credit or subsidy by purchasing coverage on Connect for Health Colorado.
- Multi-State Plans are overseen by the U.S. Office of Personnel Management (OPM) and are similar to the other Qualified Health Plan products offered on the Exchange. Generally, the same requirements that apply to other products also apply to Multi-State Plan products. The name "Multi-State Plan" does NOT mean consumers have health plan coverage for non-urgent care in multiple states.

	Anthem Bronze Pathway X HMO 25% for HSA	Anthem Bronze Pathway X HMO 0% for HSA	Anthem Silver Pathway X HMO 1250/35%	Anthem Silver DirectAccess a Multi State Plan
Network Name[1]	Pathway X	Pathway X	Pathway X	Pathway X
Individual Deductible *(Family[2] = 2 x Individual amount)*	$3,600	$6,300	$1,250	$1,750
Individual Out-of-pocket Limit *(includes deductible, copays, coinsurance and pharmacy. Family = 2 x Individual amount)*	$6,450	$6,300	$6,350	$6,600
Coinsurance	25% coinsurance	0% coinsurance	35% coinsurance	20% coinsurance
Office Visit: Primary Care Physician *(PCP) (includes post natal visits)* Note: Other office services subject to deductible and plan coinsurance	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance	$35 copay per visit for first 2 office visits, then deductible and 35% coinsurance	$35 copay per visit for first 2 office visits, then deductible and 20% coinsurance
Office Visit: Specialist	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance	Deductible, then 35% coinsurance	Deductible, then 20% coinsurance
Outpatient Diagnostic *(Examples: X-ray, EKG)* and Outpatient Advanced Diagnostic Tests *(Examples: MRI, CT scan)*	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance	Deductible, then 35% coinsurance	Deductible, then 20% coinsurance
Preventive Care[3]	No additional cost to you	No additional cost to you	No additional cost to you	No additional cost to you
Urgent Care	Deductible, then $50 copay and 25% coinsurance	Deductible, then 0% coinsurance	Deductible, then $50 copay and 35% coinsurance	Deductible, then $50 copay and 20% coinsurance
Emergency Room Care	Deductible, then $200 copay and 25% coinsurance	Deductible, then 0% coinsurance	Deductible, then $200 copay and 35% coinsurance	Deductible, then $200 copay and 20% coinsurance
Hospital: Inpatient Admission *(e.g. hospital room)(includes maternity, mental health and substance abuse)*	Deductible, then $500 copay and 25% coinsurance	Deductible, then 0% coinsurance	Deductible, then $500 copay and 35% coinsurance	Deductible, then 20% coinsurance
Hospital: Outpatient Surgery Hospital Facility Maternity *(includes delivery and all inpatient services)*	Deductible, then $500 copay and 25% coinsurance	Deductible, then 0% coinsurance	Deductible, then $500 copay and 35% coinsurance	Deductible, then 20% coinsurance
Retail Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible
Retail Pharmacy Tier 1[4,5]	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance	$15 copay	$15 copay
Retail Pharmacy Tier 2[4,5]	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance	$40 copay	$40 copay
Retail Pharmacy Tier 3[4,5]	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance	Deductible, then 35% coinsurance	Deductible, then 20% coinsurance
Retail Pharmacy Tier 4[4,5]	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance	Deductible, then 35% coinsurance	Deductible, then 20% coinsurance
Dental[6,7]	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered
Vision	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered
Mental Health and Substance Abuse: Outpatient Facility & Services	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance	Deductible, then 35% coinsurance	Deductible, then 20% coinsurance
Physical, Occupational and Speech Therapy[8]	Deductible, then 25% coinsurance	Deductible, then 0% coinsurance	Deductible, then 35% coinsurance	Deductible, then 20% coinsurance

More about our plans...

†**Mountain Enhanced X** Network is available in the following communities only: La Plata county (Durango),Montezuma county (Cortez), Summit county (Keystone/Frisco/Breckenridge) and Eagle county (Vail Valley).

[1]Our **Pathway X** and **Mountain Enhanced X** plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with these HMO plans.

[2]Our plans, with the exception of HSA plans, have **embedded family deductibles** where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits. Our HSA plans have **non-embedded family deductibles** where all family members share one common family deductible.

[3]Nationally recommended **preventive care services** received from in-network providers have no copay and no deductible requirement. **Preventive care services** consist of certain services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

[4]**Prescription drugs:** You'll use the home delivery pharmacy, managed by Express Scripts, Inc., instead of a retail pharmacy, for drugs you take on a regular basis (e.g. maintenance medicines). If you are taking a maintenance medication, you may get the first 30-day supply, plus one additional 30-day refill of the same maintenance medication, at your local retail pharmacy. You must then use the home delivery pharmacy.

[5]**Prescription drugs:** Covered medications are assigned to certain tiers (or levels) based on cost, availability and similar alternatives. Our plans have multiple tiers. Tier 1 medications may have a lower cost share for the member.

[6]**Pediatric dental** is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

[7]The **pediatric dental** policy DOES NOT provide any dental benefits to individuals age nineteen (19) or older. The pediatric dental policy is offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. A person age nineteen (19) or older will need to buy a separate adult plan if they want adult dental benefits. The pediatric dental policy WILL NOT pay for any adult dental care.

[8]**Physical, occupational or speech 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.

- You may qualify for a tax credit subsidy or cost share reduction on Silver plans. Check with your broker or Anthem authorized representative for more information and to find out if you qualify for a tax credit or subsidy by purchasing coverage on Connect for Health Colorado.
- Multi-State Plans are overseen by the U.S. Office of Personnel Management (OPM) and are similar to the other Qualified Health Plan products offered on the Exchange. Generally, the same requirements that apply to other products also apply to Multi-State Plan products. The name "Multi-State Plan" does NOT mean consumers have health plan coverage for non-urgent care in multiple states.

	Anthem Silver Pathway X HMO 2000/25%	Anthem Silver Mountain Enhanced X HMO 2000/25% †	Anthem Silver Pathway X HMO 2250/10%	Anthem Silver Pathway X HMO 2500/10%
Network Name[1]	Pathway X	Mountain Enhanced X	Pathway X	Pathway X
Individual Deductible *(Family[2] = 2 x Individual amount)*	$2,000	$2,000	$2,250	$2,500
Individual Out-of-pocket Limit *(includes deductible, copays, coinsurance and pharmacy. Family = 2 x Individual amount)*	$6,350	$6,350	$6,350	$6,600
Coinsurance	25% coinsurance	25% coinsurance	10% coinsurance	10% coinsurance
Office Visit: Primary Care Physician *(PCP)* *(includes post natal visits)* Note: Other office services subject to deductible and plan coinsurance	$35 copay per office visit, unlimited	$35 copay per office visit, unlimited	Deductible, then 10% coinsurance	$40 copay per visit for first 3 office visits, then deductible and 10% coinsurance
Office Visit: Specialist	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Outpatient Diagnostic *(Examples: X-ray, EKG)* and Outpatient Advanced Diagnostic Tests *(Examples: MRI, CT scan)*	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Preventive Care[3]	No additional cost to you	No additional cost to you	No additional cost to you	No additional cost to you
Urgent Care	Deductible, then $50 copay and 25% coinsurance	Deductible, then $50 copay and 25% coinsurance	Deductible, then $50 copay and 10% coinsurance	Deductible, then $50 copay and 10% coinsurance
Emergency Room Care	Deductible, then $200 copay and 25% coinsurance	Deductible, then $200 copay and 25% coinsurance	Deductible, then $200 copay and 10% coinsurance	Deductible, then $200 copay and 10% coinsurance
Hospital: Inpatient Admission *(e.g. hospital room)(includes maternity, mental health and substance abuse)*	Deductible, then $500 copay and 25% coinsurance	Deductible, then $500 copay and 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then $500 copay and 10% coinsurance
Hospital: Outpatient Surgery Hospital Facility Maternity *(includes delivery and all inpatient services)*	Deductible, then 25% coinsurance Deductible, then $500 copay and 25% coinsurance	Deductible, then 25% coinsurance Deductible, then $500 copay and 25% coinsurance	Deductible, then 10% coinsurance Deductible, then 10% coinsurance	Deductible, then 10% coinsurance Deductible, then $500 copay and 10% coinsurance
Retail Pharmacy Deductible	Combined with medical deductible	Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible
Retail Pharmacy Tier 1[4,5]	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	$15 copay	$15 copay
Retail Pharmacy Tier 2[4,5]	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	$40 copay	$40 copay
Retail Pharmacy Tier 3[4,5]	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Retail Pharmacy Tier 4[4,5]	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Dental[6,7]	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered
Vision	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered
Mental Health and Substance Abuse: Outpatient Facility & Services	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Physical, Occupational and Speech Therapy[8]	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance

More about our plans...

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[1]Our **Pathway X** and **Mountain Enhanced X** plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with these HMO plans.

[2]Our plans, with the exception of HSA plans, have **embedded family deductibles** where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits. Our HSA plans have **non-embedded family deductibles** where all family members share one common family deductible.

[3]Nationally recommended **preventive care services** received from in-network providers have no copay and no deductible requirement. **Preventive care services** consist of certain services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

[4]**Prescription drugs:** You'll use the home delivery pharmacy, managed by Express Scripts, Inc., instead of a retail pharmacy, for drugs you take on a regular basis (e.g. maintenance medicines). If you are taking a maintenance medication, you may get the first 30-day supply, plus one additional 30-day refill of the same maintenance medication, at your local retail pharmacy. You must then use the home delivery pharmacy.

[5]**Prescription drugs:** Covered medications are assigned to certain tiers (or levels) based on cost, availability and similar alternatives. Our plans have multiple tiers. Tier 1 medications may have a lower cost share for the member.

[6]**Pediatric dental** is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

[7]The **pediatric dental** policy DOES NOT provide any dental benefits to individuals age nineteen (19) or older. The pediatric dental policy is offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. A person age nineteen (19) or older will need to buy a separate adult plan if they want adult dental benefits. The pediatric dental policy WILL NOT pay for any adult dental care.

[8]**Physical, occupational or speech 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.

- You may qualify for a tax credit subsidy or cost share reduction on Silver plans. Check with your broker or Anthem authorized representative for more information and to find out if you qualify for a tax credit or subsidy by purchasing coverage on Connect for Health Colorado.
- Multi-State Plans are overseen by the U.S. Office of Personnel Management (OPM) and are similar to the other Qualified Health Plan products offered on the Exchange. Generally, the same requirements that apply to other products also apply to Multi-State Plan products. The name "Multi-State Plan" does NOT mean consumers have health plan coverage for non-urgent care in multiple states.

	Anthem Gold DirectAccess a Multi State Plan	Anthem Gold Mountain Enhanced X HMO 1100/10% †
Network Name[1]	Pathway X	Mountain Enhanced X
Individual Deductible *(Family[2] = 2 x Individual amount)*	$1,100	$1,100
Individual Out-of-pocket Limit *(includes deductible, copays, coinsurance and pharmacy. Family = 2 x Individual amount)*	$6,000	$6,600
Coinsurance	10% coinsurance	10% coinsurance
Office Visit: Primary Care Physician *(PCP)* *(includes post natal visits)* Note: Other office services subject to deductible and plan coinsurance	$25 copay per office visit, unlimited	$20 copay per office visit, unlimited
Office Visit: Specialist	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Outpatient Diagnostic *(Examples: X-ray, EKG)* and Outpatient Advanced Diagnostic Tests *(Examples: MRI, CT scan)*	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Preventive Care[3]	No additional cost to you	No additional cost to you
Urgent Care	Deductible, then $50 copay and 10% coinsurance	Deductible, then $50 copay and 10% coinsurance
Emergency Room Care	Deductible, then $200 copay and 10% coinsurance	Deductible, then $200 copay and 10% coinsurance
Hospital: Inpatient Admission *(e.g. hospital room)(includes maternity, mental health and substance abuse)*	Deductible, then $500 copay and 10% coinsurance	Deductible, then $500 copay and 10% coinsurance
Hospital: Outpatient Surgery Hospital Facility	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Maternity *(includes delivery and all inpatient services)*	Deductible, then $500 copay and 10% coinsurance	Deductible, then $500 copay and 10% coinsurance
Retail Pharmacy Deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible	Tiers 1, 2: No deductible Tiers 3, 4: Combined with medical deductible
Retail Pharmacy Tier 1[4,5]	$15 copay	$15 copay
Retail Pharmacy Tier 2[4,5]	$40 copay	$40 copay
Retail Pharmacy Tier 3[4,5]	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Retail Pharmacy Tier 4[4,5]	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Dental[6,7]	Pediatric dental covered Adult dental not covered	Pediatric dental covered Adult dental not covered
Vision	Pediatric vision covered Adult vision not covered	Pediatric vision covered Adult vision not covered
Mental Health and Substance Abuse: Outpatient Facility & Services	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance
Physical, Occupational and Speech Therapy[8]	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance

More about our plans...

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[1]Our **Pathway X** and **Mountain Enhanced X** plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with these HMO plans.

[2]Our plans, with the exception of HSA plans, have **embedded family deductibles** where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits. Our HSA plans have **non-embedded family deductibles** where all family members share one common family deductible.

[3]Nationally recommended **preventive care services** received from in-network providers have no copay and no deductible requirement. **Preventive care services** consist of certain services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

[4]**Prescription drugs:** You'll use the home delivery pharmacy, managed by Express Scripts, Inc., instead of a retail pharmacy, for drugs you take on a regular basis (e.g. maintenance medicines). If you are taking a maintenance medication, you may get the first 30-day supply, plus one additional 30-day refill of the same maintenance medication, at your local retail pharmacy. You must then use the home delivery pharmacy.

[5]**Prescription drugs:** Covered medications are assigned to certain tiers (or levels) based on cost, availability and similar alternatives. Our plans have multiple tiers. Tier 1 medications may have a lower cost share for the member.

[6]**Pediatric dental** is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

[7]The **pediatric dental** policy DOES NOT provide any dental benefits to individuals age nineteen (19) or older. The pediatric dental policy is offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. A person age nineteen (19) or older will need to buy a separate adult plan if they want adult dental benefits. The pediatric dental policy WILL NOT pay for any adult dental care.

[8]**Physical, occupational or speech 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.

- You may qualify for a tax credit subsidy or cost share reduction on Silver plans. Check with your broker or Anthem authorized representative for more information and to find out if you qualify for a tax credit or subsidy by purchasing coverage on Connect for Health Colorado.
- Multi-State Plans are overseen by the U.S. Office of Personnel Management (OPM) and are similar to the other Qualified Health Plan products offered on the Exchange. Generally, the same requirements that apply to other products also apply to Multi-State Plan products. The name "Multi-State Plan" does NOT mean consumers have health plan coverage for non-urgent care in multiple states.

Get help today!

Call your broker or Anthem authorized representative or visit us online at anthem.com where you can view and compare plan options.

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- Review the Booklet.
- Call your broker or Anthem authorized 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 www.sbc.anthem.com > Select Member.

Anthem Blue Cross and Blue Shield, through its subsidiary company, HMO Colorado, is pleased to offer health plans through Connect for Health Colorado. Learn more about Connect for Health Colorado and financial assistance at www.ConnectforHealthCO.com.

In accordance with the Affordable Care Act, benefits, formularies, pharmacy and provider networks, premiums and copayments/coinsurance for these plans may change on January 1 of each year.

Anthem does not discriminate based on race, color, ethnicity, national origin, religion, age, gender, gender identity, mental or physical disabilities, sexual orientation, genetic information, including pregnancy and expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health condition or health status in the administration of the plan, including enrollment, marketing practices, benefit designs, and benefit determinations.

Your HSA: Convenience, savings and flexibility all rolled into one

Introducing BenefitWallet:

Setting up a Health Savings Account (HSA)

To realize your plan's full financial power, consider selecting a plan with an HSA account. The portability and tax savings of an HSA account can add up fast.

We've joined with BenefitWallet®, A Xerox Solution, to integrate its HSA Solution into a selection of our plans. Setting up your account with BenefitWallet is easy. Plus, 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 special checks and automatic fund transfers
- Competitive interest rates and investment opportunities for the funds in your account
- Mobile App for iPhone®, iPad® and AndroidTM devices and mobile access from any mobile device
- 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)

Of course, if you'd rather use another financial institution for your account, that's fine, too.

You're only one checkmark away

Simply make the selection on your application form. We'll take care of setting up your account. We'll also take care of sending you a *Welcome Kit* to get you started. All you have to take care of is your health. Which is, after all, the most important thing.

A closer look

HSA Welcome Kit

If you make the selection on your application form, your HSA will automatically be set up — no set-up fee required, and you'll soon receive an HSA Welcome Kit. In it, you'll find all of the banking documentation and instructions for using and opening 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 families. Once you're ready to invest, login to your account and select "Investments" from the Quick Links menu or contact the BenefitWallet Service Center at **866-686-4798**, Monday through Friday, from 8 a.m. to 11 p.m. ET, for more information or to begin investing.

Debit cards, checkbooks and online banking

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

Deposits to your account

To contribute to your HSA, simply 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. Or, you can set up an electronic funds transfer between your bank and BenefitWallet for one-time or recurring account contributions.

Account activity statements

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. For an additional fee of $1.25 per month, you can receive a paper statement. Please go to 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 in your HSA Welcome Kit. 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, 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.**

Coverage Brief for Connect for Health Colorado

Anthem BlueCross BlueShield

Things you should know before you buy these plans...

Anthem Bronze Pathway X HMO plans 5000/40%, 5750/30%, 6250/20%, 25% for HSA and 0% for HSA; Anthem Bronze Mountain Enhanced X HMO 5000/40%; Anthem Silver DirectAccess a Multi State Plan; Anthem Silver Pathway X HMO plans 1250/35%, 2000/25%, 2250/10% and 2500/10%; Anthem Silver Mountain Enhanced X HMO 2000/25%; Anthem Gold DirectAccess a Multi State Plan; Anthem Gold Mountain Enhanced X HMO 1100/10%; and Anthem Catastrophic Pathway X HMO 6600/0%

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 United States citizen or a lawfully present non-citizen and a legal resident of the State of Colorado and not entitled to or enrolled in Medicare. 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.

Open Enrollment

As established by the rules of the Exchange, individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period.

American Indians are authorized to move from one QHP to another QHP once per month.

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 calendar year. A subscriber's actual effective date is determined by the date he or she submits a complete application and any necessary documents or payments to the Exchange.

Guaranteed Renewable

Coverage under the Booklet is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law.

As a member, you may renew the Booklet by payment of the renewal premium by the end of the grace period of the premium due date, provided the following requirements are satisfied:

1. Eligibility criteria, as set forth in the Booklet, continues to be met;
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of the Booklet; and
3. Membership has not been terminated by the Exchange.

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 physician (PCP), specialty care physician (SCP), or other in-network providers.

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 a non-network service, except for emergency care or urgent care, or as an authorized service.

Out-of-network Providers

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; 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. In addition, certain services are not covered unless obtained from an in-network provider. See your Summary of Benefits.

For services rendered by an out-of-network provider, you may be 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;
- Non-covered services;

- Filing claims;
- Higher cost-sharing amounts

How to Find a Provider in the Network

There are three ways you can find out if a provider or facility is in the network for one of these plans. You can also find out where they are located and details about their license or training.

- See your Plan's directory of in-network providers at anthem.com, which lists the doctors, providers, and facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of doctors and providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your doctor or provider.

When using the Find a Doctor tool, be sure to include the plan network (Pathway X or Mountain Enhanced X) as search criteria for the plan you are considering.

If you want to see if your provider is in the network for a particular plan, you can also search the provider directory on Connect for Health Colorado.

If you need help choosing a doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

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

If you or a family member needs 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 Management

Utilization management (UM) 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 UM 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 needed. The UM review team checks to make sure the treatment meets certain rules set by your health plan. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The UM review team will let you and your doctor know as soon as possible.

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

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

- A 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, like physical therapy or mental health counseling;
- Durable medical equipment (DME), like wheelchairs, walkers, crutches, hospital beds and more

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 in a doctor's office, regular office visits, physical therapy or mental health therapy, home health care, durable medical equipment, a stay in a nursing home, mental health care visits and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically needed.

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

We do a retrospective review when you have already had surgery or another type of medical care. When the UM 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 needed.

Case Management

Case managers are licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

Preauthorization

Preauthorization 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 preauthorization guidelines regularly. Preauthorization is also called "precertification," "prior authorization," or "pre-approval."

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Here's how getting preauthorization can help you out:

Saving time. Preauthorizing services can save a step since you will know if you are eligible and what your benefits are before you get the service. The doctors in our network ask for preauthorization 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 preauthorization or call us to ask. The doctor's office will ask for preauthorization for you. Plus, costs are usually lower with an in-network doctor. If you ever have a question about whether you need preauthorization, just call the preauthorization or precertification phone number on your ID card.

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.

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
- Allergy tests and treatment as specified in the Booklet
- Alternative or complementary medicine
- Artificial and mechanical devices
- Bariatric surgery
- 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 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)
- Cochlear implants
- Comfort and/or convenience items
- Corrective eye surgery
- Cosmetic surgery and/or treatment that's primarily intended to improve your appearance
- Custodial ordered care as described in the exclusions
- Dental, except as described in the Booklet
- Educational/training services
- Experimental or investigative treatment and any resulting complications
- Feet - surgical treatment
- Foot care - routine
- Infertility testing and treatment
- Manipulation therapy, regardless of which type of provider performs the therapy
- Nutritional and dietary supplements, over-the-counter drugs, devices or products
- Pharmacy, except as described in the Booklet
- Physical fitness such as health club memberships, exercise equipment, etc.
- 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 your Booklet 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 Booklet as a covered service
- Vein treatment – treatment of varicose veins or telanqiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes
- Vision, except as described in the Booklet
- Weight loss programs or treatment of obesity except as mandated
- Workers' compensation

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:

- Applied behavior analysis for autism
  - From birth through age 8: 550 sessions, 25 minutes in length per year
  - Age 9-19: 185 sessions 25 minutes in length per year
  - Depending on the law, you may be entitled to exceed these maximums
- Therapy services (rehabilitative care) - An equal number of therapy visits are available for habilitative care
  - Physical therapy – 20 visits per member per year
  - Occupational therapy – 20 visits per member per year
  - Speech therapy – 20 visits per member per year
- Hearing aids – 1 pair every 5 years for members under age 18

- Home health care – 28 hours per week
- Skilled nursing facility – 100 days per year

To access a Summary of Benefits and Coverage (SBC) and the CO SBC Supplement, please visit www.sbc.anthem.com > Select Member.

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In accordance with the Affordable Care Act, benefits, formularies, pharmacy and provider networks, premiums and copayments/coinsurance for these plans may change on January 1 of each year.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Benefit Snapshot and Coverage Brief. If you did not receive one or more of these materials, please contact your Anthem authorized representative to request them.