



HOW TO CHOOSE AND USE YOUR HEALTH PLAN

Get the answers you need with this helpful guide

Colorado

2020 Plan Year

Individual and Family
Bronze, Silver and Catastrophic plans

Open Enrollment period runs
November 1, 2019 - January 15, 2020

WHY CHOOSE ANTHEM?

When you choose an Individual or Family insurance plan with Anthem Blue Cross and Blue Shield, you'll have access to leading doctors and hospitals. You can even have a private video visit with a doctor or therapist on your smartphone, tablet or computer. And included with every medical plan, you'll get pharmacy coverage, too.

One stop coverage for all your needs

You can coordinate your medical, vision, dental and term life coverage. It's easy and can result in better care delivered sooner at a lower cost. Plus, preventive care is offered for as low as \$0, with no copay or deductible to meet when it's received from doctors in your plan.

Trusted brand name

One in three Americans carries a Blue branded card, which is accepted by providers, such as doctors and hospitals, across the country.¹

Local presence

Our families live and work here – and we've been committed to improving the health of Coloradans like you since 1938.

We understand your needs are unique

That's why we offer health plan choices to help you be your best. We also have many extra benefits you may not be aware of. Take a look.

Convenient options for care:

- With **LiveHealth Online**, you can visit a board certified doctor, psychologist, or therapist using your smartphone, tablet, or computer with a webcam - in both English and Spanish. Doctors are available 24/7 to assess your condition and if it's needed, they can send a prescription to your local pharmacy.²
- With **24/7 NurseLine**, you can call a registered nurse with your health questions or concerns any time, day or night. You can also use the toll free line to access an AudioHealth Library.
- Get personalized information about your health plan through the **Sydney mobile app** or **anthem.com**. Self service tools allow you to see your claims and coverage details, refill prescriptions, estimate the costs of common procedures, make monthly premium payments and much more.

MyHealth Advantage

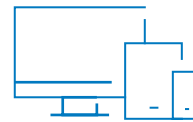
This program tracks your health and pharmacy claims to see if there are any gaps in care or ways to save money. If so, you get a personalized, confidential MyHealth Note in the mail. You can also download the Sydney mobile app to receive your MyHealth Notes electronically through the Mobile Inbox.

¹ https://www.bcbs.com/sites/default/files/file-attachments/page/Blue_Facts_Sheet-2019.pdf

² Prescription availability is defined by physician judgment and state regulations. LiveHealth Online is the trade name of Health Management Corporation. Visit livehealthonline.com to learn more.

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QUICK CLICKS

Get the info you want now. Just pick a topic to take you right to that section.

- Health care plans
- Networks (doctors in your plan)
- Find a Doctor
- Prescriptions

WHAT YOU NEED TO KNOW TO CHOOSE A PLAN

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

Connecting dental and vision coverage to your medical plan is important to overall health.

- 90% of the body's diseases first show signs and symptoms in the mouth¹
- 1 in 5 cases of tooth loss is linked to diabetes²
- 22 of the top 25 prescribed medications can have an impact on vision³

Essential pediatric dental and vision benefits are included with our medical plans.⁴ Anthem knows how important both dental and vision care is to overall health, so we also offer stand-alone plans to you and your family with great care from leading doctors. When you have medical, dental and vision coverage through Anthem, we connect all of your providers with Anthem Whole Health Connection[®]. It's a program that helps improve your member experience by focusing on your whole person health. Plus, connecting dental and vision benefits with your medical plan offers the convenience of one bill, one ID card and one digital experience.



Pharmacy

Our health plans include coverage for prescription drugs. Did you know that pharmacy is the most widely used benefit – 4x more than medical?[†] Getting the most out of your pharmacy benefits can help keep you healthy and save you money.

Manage your drug costs:

Your plan includes coverage for hundreds of brand and generic drugs. You can save money by talking to your doctor about lower cost alternatives. To see if your drug is covered, go to anthem.com/pharmacyinformation and choose the **Colorado Select Drug List**.

Fill your prescription the way you choose:

- **Retail Pharmacies**

Your pharmacy benefit uses the Rx Choice Tiered Network which offers levels of preferred and non-preferred pharmacies. Use a preferred (Level 1) pharmacy to get lower cost options at well-known chains like CVS, Walmart, Costco and Kroger. To see if your pharmacy is in the plan's network, visit anthem.com/pharmacyinformation/rxnetworks.html and select the Colorado Rx Choice Tiered Network.

- **Home Delivery**

With home delivery, you can get up to a 90-day supply of your maintenance medications - drugs used to treat long-term conditions like high blood pressure or diabetes - **delivered right to your door!** By using our home delivery pharmacy, you're more likely to follow your drug treatment plan resulting in better health outcomes.[◇]

¹ Academy of General Dentistry Know Your Teeth website: Warning Signs in the Mouth Can Save Lives (accessed August 2019); knowyourteeth.com

² <https://www.mouthhealthy.org/en/az-topics/d/diabetes>

³ Anthem analysis of top utilized drugs and the side effects as described in Lippincott Drug Guide for Nurses, 2018

⁴ Adult dental and vision coverage are not considered essential health benefits under ACA plan guidelines

[†] Ambulatory Care Use and Physician office visits, US Centers for Disease Control and Prevention (accessed 2/16/2017). Retail Prescription Drugs Filled at Pharmacies (Annual per Capita) (accessed 2/16/2017); kff.org

[◇] Schwab P, Racska P, Rascati K, Mourer M, Meah Y, Worley K. A Retrospective Database Study Comparing Diabetes-related Medication Adherence and Health Outcomes for Mail-order versus Community Pharmacy. *J Manag Care Spec Pharm* 2019 Mar;25(3):332-40: ncbi.nlm.nih.gov/pubmed/30816817.

WHAT YOU NEED TO KNOW TO CHOOSE A PLAN

MORE OPTIONS FOR COVERAGE



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.



Additional Coverage

For additional coverage or for the unexpected, you have choices. There are a variety of plans that offer coverage for accidents, critical illness, hospital stays and more available from LifeSecure™*. While these are not Affordable Care Act-compliant plans, they offer reasonably priced coverage for specific benefits. And, when paired with an Anthem health plan, these plans can provide more complete coverage and better financial protection. A representative can help you with additional coverage options from LifeSecure to fit your needs.



TO LEARN MORE

Call your broker or Anthem 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 your broker or Anthem representative.

* LifeSecure Insurance Company ("LifeSecure") underwrites and has sole financial responsibility for the Accident, Critical Illness and Hospital Recovery insurance products. LifeSecure is an independent company and there is no ownership affiliation between LifeSecure and Anthem Blue Cross and Blue Shield. LifeSecure products do not offer qualifying health coverage ("Minimum Essential Coverage" or "MEC") that satisfies the health coverage under the Affordable Care Act. The termination or loss of one of these policies does not entitle you to a Special Enrollment Period to purchase a health benefit plan that qualifies as MEC outside of an Open Enrollment Period.

ANSWERS TO YOUR QUESTIONS

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.

HOW DO I CHOOSE A PLAN?

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:

- How often do you see doctors and specialists?
- What prescription medications do you take regularly?
- Are you planning any procedures this year?

See Find a Doctor instructions, Pharmacy coverage details and read about the plan choices below to see which plan best fits your needs.

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.
- **Catastrophic:** 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.

ANSWERS TO YOUR QUESTIONS



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.



WHY SET UP A HEALTH SAVINGS ACCOUNT?

You may be able to lower your health care costs and your taxes with a health savings account (HSA). You can easily set up a health savings account with Anthem's banking partner after selecting an HSA-compatible health plan. When you use Anthem's integrated banking partner, you will have easy access to view and pay your claims all in one convenient location. An HSA can offer a variety of tax advantages, including paying for qualified out-of-pocket medical expenses using tax-free dollars.



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.

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.¹ 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 Select **Find a Doctor** at the top right of your screen.
- 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.
- Not all networks are available in all counties. Archuleta, Eagle, La Plata, Mesa, Moffat, Montezuma, Rio Blanco and Summit counties offer both the **Pathway** and **Mountain Enhanced** networks. All other Colorado counties offer the **Pathway** network only.
- **If you are online, click here to see our county network coverage map or refer to your paper kit for more details.**

¹ While we make efforts to ensure that our lists of doctors, hospitals, and other providers are up to date and accurate, providers do leave our networks from time to time, and the listings included on *Find a Doctor* at [anthem.com](https://www.anthem.com) do change.

MEMBER ADVANTAGES

Making informed health care decisions for you and your family is simple with our website, mobile app and online care options.

ONLINE TOOLS

No matter which plan you choose, you can register at anthem.com or on the Sydney mobile app to get personalized information about your health plan all in one place.



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 Sydney 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.

CONVENIENT ONLINE CARE

Have a private video visit with a board-certified doctor or licensed therapist through LiveHealth Online.



LiveHealth Online

- No need to sit in a waiting room or even leave home for non-emergencies.

Talk to a doctor whenever, wherever with LiveHealth Online

Easy:

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

Face-to-face:

Chat by two-way video for common health issues, like a cold, the flu, allergies and more.

Save:

On average members save on care, compared to ER, urgent care, or other health facilities.

LiveHealth Online Psychology offers virtual counseling

Convenient:

Visits available 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, when available.

Same cost:

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

MEMBER 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

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 HMO 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 Sydney mobile 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.

SPECIAL SAVINGS FROM SPECIALOFFERS¹

Members can get discounts on products and services, including vitamins, weight loss support, glasses and contacts, sports gear and fitness club memberships, that help promote better health and wellbeing. **You can even get a 20% discount on a 23andME[®] Ancestry kit and \$40 off each Health + Ancestry kit.**

¹ SpecialOffers discounts are subject to change without notice.

PLAN BENEFIT CHARTS

Not all networks are available in all counties. Archuleta, Eagle, La Plata, Mesa, Moffat, Montezuma, Rio Blanco and Summit counties offer both the **Pathway** and **Mountain Enhanced** networks. All other Colorado counties offer the **Pathway** network only. If you are online, click here to see our county network coverage map or refer to your paper kit for more details.

	Anthem Bronze Mountain Enhanced HMO 5000 (4CR5)	Anthem Bronze Mountain Enhanced HMO 6000 (4CQX)	Anthem Bronze Mountain Enhanced HMO 6850 for HSA (4CR0)
Network name	Mountain Enhanced	Mountain Enhanced	Mountain Enhanced
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$5,000	\$6,000	\$6,850
Individual out-of-pocket maximum	\$8,150	\$8,150	\$6,850
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 3 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 1: Level 1 / Level 2	\$30 copay / \$40 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2: Level 1 / Level 2	\$75 copay / \$85 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3: 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 ² (limits apply)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Speech therapy ² (limits apply)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance

Please see Medical plans footnotes on page 19.

PLAN BENEFIT CHARTS

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	Anthem Bronze Mountain Enhanced HMO 8150 (4CRF)	Anthem Bronze Pathway HMO 5000 (4CR4)	Anthem Bronze Pathway HMO 6000 (4CR2)
Network name	Mountain Enhanced	Pathway	Pathway
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$8,150	\$5,000	\$6,000
Individual out-of-pocket maximum	\$8,150	\$8,150	\$8,150
Coinsurance (percentage may vary for some covered services)	0%	40%	30%
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)	\$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance	\$50 copay per visit for the first 2 visits, then deductible and 40% coinsurance	\$45 copay per visit for the first 3 visits, then deductible and 30% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 0% coinsurance	Deductible, then \$250 copay and 40% coinsurance	Deductible, then \$500 copay and 30% coinsurance
Urgent care	Deductible, then 0% coinsurance	\$100 copay	\$100 copay
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 0% coinsurance	Deductible, then \$200 copay and 40% coinsurance	Deductible, then \$200 copay and 30% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance	Deductible, then \$1,000 copay and 40% coinsurance	Deductible, then \$500 copay and 40% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% 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, 3, 4: Medical deductible applies
Retail pharmacy tier 1: Level 1 / Level 2	0% coinsurance / 0% coinsurance	\$30 copay / \$40 copay	30% coinsurance / 40% coinsurance
Retail pharmacy tier 2: Level 1 / Level 2	0% coinsurance / 0% coinsurance	\$75 copay / \$85 copay	30% coinsurance / 40% coinsurance
Retail pharmacy tier 3: Level 1 / Level 2	0% coinsurance / 0% coinsurance	\$150 copay / \$160 copay	30% coinsurance / 50% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	0% coinsurance / 0% coinsurance	\$650 copay / \$660 copay	30% coinsurance / 50% coinsurance
Physical and occupational therapy ² (limits apply)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance
Speech therapy ² (limits apply)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance

Please see Medical plans footnotes on page 19.

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	Anthem Bronze Pathway HMO 6850 for HSA (4CR1)	Anthem Bronze Pathway HMO 8150 (4CRD)	Anthem Silver Mountain Enhanced HMO 2000 30% (4CQM)
Network name	Pathway	Pathway	Mountain Enhanced
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$6,850	\$8,150	\$2,000
Individual out-of-pocket maximum	\$6,850	\$8,150	\$7,500
Coinsurance (percentage may vary for some covered services)	0%	0%	30%
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)	Deductible, then 0% coinsurance	\$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance	\$35 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 30% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 30% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then \$250 copay and 30% coinsurance
Urgent care	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	\$100 copay
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then \$200 copay and 30% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then \$500 copay and 30% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 30% 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: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1: Level 1 / Level 2	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	30% coinsurance / 40% coinsurance
Retail pharmacy tier 2: Level 1 / Level 2	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	30% coinsurance / 40% coinsurance
Retail pharmacy tier 3: Level 1 / Level 2	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	30% coinsurance / 50% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	30% coinsurance / 50% coinsurance
Physical and occupational therapy ² (limits apply)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 30% coinsurance
Speech therapy ² (limits apply)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 30% coinsurance

Please see Medical plans footnotes on page 19.

PLAN BENEFIT CHARTS

Not all networks are available in all counties. Archuleta, Eagle, La Plata, Mesa, Moffat, Montezuma, Rio Blanco and Summit counties offer both the **Pathway** and **Mountain Enhanced** networks. All other Colorado counties offer the **Pathway** network only. If you are online, click here to see our county network coverage map or refer to your paper kit for more details.

	Anthem Silver Mountain Enhanced HMO 3000 15% (4CQP)	Anthem Silver Mountain Enhanced HMO 4500 25% (4CRW)	Anthem Silver Mountain Enhanced HMO 5150 35% (4CQS)
Network name	Mountain Enhanced	Mountain Enhanced	Mountain Enhanced
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$3,000	\$4,500	\$5,150
Individual out-of-pocket maximum	\$8,150	\$8,150	\$6,800
Coinsurance (percentage may vary for some covered services)	15%	25%	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)	\$40 copay per visit for the first 3 visits, then deductible and 15% coinsurance	\$40 copay per visit for the first 3 visits, then deductible and 25% coinsurance	\$35 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 15% coinsurance	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 15% coinsurance	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then \$500 copay and 15% coinsurance	Deductible, then \$300 copay and 50% 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 \$500 copay and 15% coinsurance	Deductible, then \$500 copay and 25% coinsurance	Deductible, then 35% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then \$500 copay and 30% coinsurance	Deductible, then \$1,000 copay and 35% coinsurance	Deductible, then 35% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 15% coinsurance	Deductible, then 25% 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: No deductible	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 1: Level 1 / Level 2	\$15 copay / \$25 copay	\$10 copay / \$20 copay	\$10 copay / \$20 copay
Retail pharmacy tier 2: Level 1 / Level 2	\$50 copay / \$60 copay	\$40 copay / \$50 copay	\$40 copay / \$50 copay
Retail pharmacy tier 3: Level 1 / Level 2	\$80 copay / \$90 copay	\$80 copay / \$90 copay	40% coinsurance / 50% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	\$500 copay / \$510 copay	\$650 copay / \$660 copay	40% coinsurance / 50% coinsurance
Physical and occupational therapy ² (limits apply)	Deductible, then 15% coinsurance	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance
Speech therapy ² (limits apply)	Deductible, then 15% coinsurance	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance

Please see Medical plans footnotes on page 19.

PLAN BENEFIT CHARTS

Not all networks are available in all counties. Archuleta, Eagle, La Plata, Mesa, Moffat, Montezuma, Rio Blanco and Summit counties offer both the **Pathway** and **Mountain Enhanced** networks. All other Colorado counties offer the **Pathway** network only. If you are online, click here to see our county network coverage map or refer to your paper kit for more details.

	Anthem Silver Mountain Enhanced HMO 5500 25% (4CQR)	Anthem Silver Pathway HMO 2000 30% (4CQL)	Anthem Silver Pathway HMO 3000 15% (4CQN)
Network name	Mountain Enhanced	Pathway	Pathway
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$5,500	\$2,000	\$3,000
Individual out-of-pocket maximum	\$7,000	\$7,500	\$8,150
Coinsurance (percentage may vary for some covered services)	25%	30%	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 30% coinsurance	Deductible, then 15% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 25% coinsurance	Deductible, then 30% coinsurance	Deductible, then 15% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 25% coinsurance	Deductible, then \$250 copay and 30% 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 30% 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 30% 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 1: Level 1 / Level 2	\$10 copay / \$20 copay	30% coinsurance / 40% coinsurance	\$15 copay / \$25 copay
Retail pharmacy tier 2: Level 1 / Level 2	\$40 copay / \$50 copay	30% coinsurance / 40% coinsurance	\$50 copay / \$60 copay
Retail pharmacy tier 3: Level 1 / Level 2	35% coinsurance / 50% coinsurance	30% coinsurance / 50% coinsurance	\$80 copay / \$90 copay
Retail pharmacy tier 4: Level 1 / Level 2	50% coinsurance / 50% coinsurance	30% coinsurance / 50% coinsurance	\$500 copay / \$510 copay
Physical and occupational therapy ² (limits apply)	Deductible, then 25% coinsurance	Deductible, then 30% coinsurance	Deductible, then 15% coinsurance
Speech therapy ² (limits apply)	Deductible, then 25% coinsurance	Deductible, then 30% coinsurance	Deductible, then 15% coinsurance

Please see Medical plans footnotes on page 19.

PLAN BENEFIT CHARTS

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	Anthem Silver Pathway HMO 4500 25% (4CRV)	Anthem Silver Pathway HMO 5150 35% (4CQT)	Anthem Silver Pathway HMO 5500 25% (4CQQ)
Network name	Pathway	Pathway	Pathway
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$4,500	\$5,150	\$5,500
Individual out-of-pocket maximum	\$8,150	\$6,800	\$7,000
Coinsurance (percentage may vary for some covered services)	25%	35%	25%
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)	\$40 copay per visit for the first 3 visits, then deductible and 25% coinsurance	\$35 copay	\$35 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then \$300 copay and 50% coinsurance	Deductible, then 35% coinsurance	Deductible, then 25% 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 \$500 copay and 25% coinsurance	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then \$1,000 copay and 35% coinsurance	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance	Deductible, then 25% 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: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies
Retail pharmacy tier 1: Level 1 / Level 2	\$10 copay / \$20 copay	\$10 copay / \$20 copay	\$10 copay / \$20 copay
Retail pharmacy tier 2: Level 1 / Level 2	\$40 copay / \$50 copay	\$40 copay / \$50 copay	\$40 copay / \$50 copay
Retail pharmacy tier 3: Level 1 / Level 2	\$80 copay / \$90 copay	40% coinsurance / 50% coinsurance	35% coinsurance / 50% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	\$650 copay / \$660 copay	40% coinsurance / 50% coinsurance	50% coinsurance / 50% coinsurance
Physical and occupational therapy ² (limits apply)	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance
Speech therapy ² (limits apply)	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance

Please see Medical plans footnotes on page 19.

PLAN BENEFIT CHARTS

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	Anthem Catastrophic Pathway HMO 8150 (4CR3)
Network name	Pathway
Plan includes out-of-network coverage?	No
Individual deductible	\$8,150
Individual out-of-pocket maximum	\$8,150
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 1: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Physical and occupational therapy ² (limits apply)	Deductible, then 0% coinsurance
Speech therapy ² (limits apply)	Deductible, then 0% coinsurance

Please see Medical plans footnotes on page 19.

PLAN BENEFIT CHARTS

The **Anthem Catastrophic PPO** plan includes out-of-network benefits. Individual deductible, Individual out-of-pocket maximum and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information shown is for in-network services only. This plan is available on the Anthem PPO network and is available in certain rating areas.

	Anthem Catastrophic PPO 8150 (4CQW)
Network name	Anthem PPO
Plan includes out-of-network coverage?	Yes
Individual deductible	\$8,150 / \$24,450 In-network / Out-of-network
Individual out-of-pocket maximum	\$8,150 / \$24,450 In-network / Out-of-network
Coinsurance (percentage may vary for some covered services)	0% / 50% In-network / Out-of-network
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 1: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Physical and occupational therapy ² (limits apply)	Deductible, then 0% coinsurance
Speech therapy ² (limits apply)	Deductible, then 0% coinsurance

Please see Medical plans footnotes on page 19.

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 **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.

EMBEDDED PEDIATRIC DENTAL BENEFITS DETAILS

Embedded pediatric dental benefits are included with all of our medical plans for members until the end of the month in which they turn 19. Coverage includes preventive care, fillings and some other major services like medically necessary orthodontia.

- Shared deductible for medical and dental services
- Shared out-of-pocket maximum for medical and dental services

	Medical plans ¹	Catastrophic medical plans
	<i>in-network</i>	<i>in-network</i>
Dental network	Dental Prime	Dental Prime
Deductible	All dental services subject to the medical deductible	All dental services subject to the medical deductible
Annual maximum (per person)	None	None
Annual out-of-pocket maximum	Combined with medical	Combined with medical
Diagnostic and preventive	<i>No waiting period</i>	<i>No waiting period</i>
Cleaning, exams, x-rays	0% coinsurance	0% coinsurance
Basic services	<i>No waiting period</i>	<i>No waiting period</i>
Fillings	50% coinsurance	0% coinsurance
Complex and major services	<i>No waiting period</i>	<i>No waiting period</i>
Endodontic/oral surgery	50% coinsurance	0% coinsurance
Major services	50% coinsurance	0% coinsurance
Dentally necessary orthodontia ²	50% coinsurance	0% coinsurance
Cosmetic orthodontia	Not covered	Not covered

1 For medical plans where the deductible equals the out-of-pocket maximum, any services subject to the deductible have coinsurance of 0% after deductible.

2 Orthodontia is usually considered dentally necessary when a child's teeth are misaligned (crooked or not spaced correctly) to the point where they don't work properly. This could cause the child to have trouble speaking or eating. Some examples would be (1) if a child can't bite into an apple because they can't close their front teeth together or (2) if a child bites into the gum tissue of the palate (roof of the mouth) when they try to bite down.

EMBEDDED PEDIATRIC VISION BENEFITS DETAILS

The following vision care services are covered for members until the end of the month in which they turn 19. Coverage may include eye exams, eye glass lenses, frames and contact lenses. The benefit period is the calendar year (January 1 through December 31).

If you purchase a Catastrophic plan, you must meet your medical deductible before pediatric vision benefits are paid.

	Benefit frequency	Cost share <i>in-network</i>
Eye exam	Once every benefit period	\$0 copay up to maximum allowed amount
Lenses (single, bifocal, trifocal and standard progressive)	Once every benefit period	\$0 copay up to maximum allowed amount
Frames	Once every benefit period	Anthem formulary ¹
Contact lenses (Non-elective)	Once every benefit period ²	Covered in full
Contact lenses (Elective/disposable)	Once every benefit period ²	Anthem formulary ¹

1 A collection of frames and lenses that can be purchased for a \$0 copay (may differ by provider).

2 Benefits for contact lenses are in lieu of the eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.

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 maximum

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 MAKE IT HAPPEN.

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, 2019 - January 15, 2020**.

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](https://www.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 links are listed on the SBC page below **NEXT**.

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 ACA, THE FOLLOWING PLAN CHANGES MAY OCCUR ANNUALLY ON JANUARY 1

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

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, C 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.

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.

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.

IMPORTANT LEGAL INFORMATION

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;
- 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

IMPORTANT LEGAL INFORMATION

- 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
- Consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications
- 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 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. إضافة من خلال الاتصال برقم خدمات الأعضاء (1-855-383-7249) (TTY/TDD: 711)

Bassa

Ɔ jũ ké m̄ dyi gbo-kpá-kpá mó b̄é m̄ ké céè-d̄é nià ke múin wó dé bãà-w̄éin wùdù d̄ò mú ní, m̄ b̄éin ɔ zòò dyiin dé M̄éjà jè gbo-gm̄ò Kpòè nòbà nià ke <1-855-383-7249> dá dá mú. M̄ se wíq̄i kàkò d̄ò p̄éin 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 iji ghọta dọkumentị a n'asụsụ dị iche, ị nwere ike iriọ ya na akwụghị ugwọ ọ bụla ọzọ site na ikpọ nọmba Orụ 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 biroodhaan 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)

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)

GET HELP IN YOUR LANGUAGE

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 nilò iránwọ kí àkọsilẹ yíí le yé ọ ní èdè mírán, o le bèrè rẹ láísí àfikún owó nípa pípe Nọmbà Àwọn ìpèsè ọmọ-ẹgbẹ (1-855-383-7249). (TTY/TDD: 711)



WE'RE HERE TO HELP

Still have questions? Just ask.

To learn more, call your broker or Anthem 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 your broker or Anthem representative.

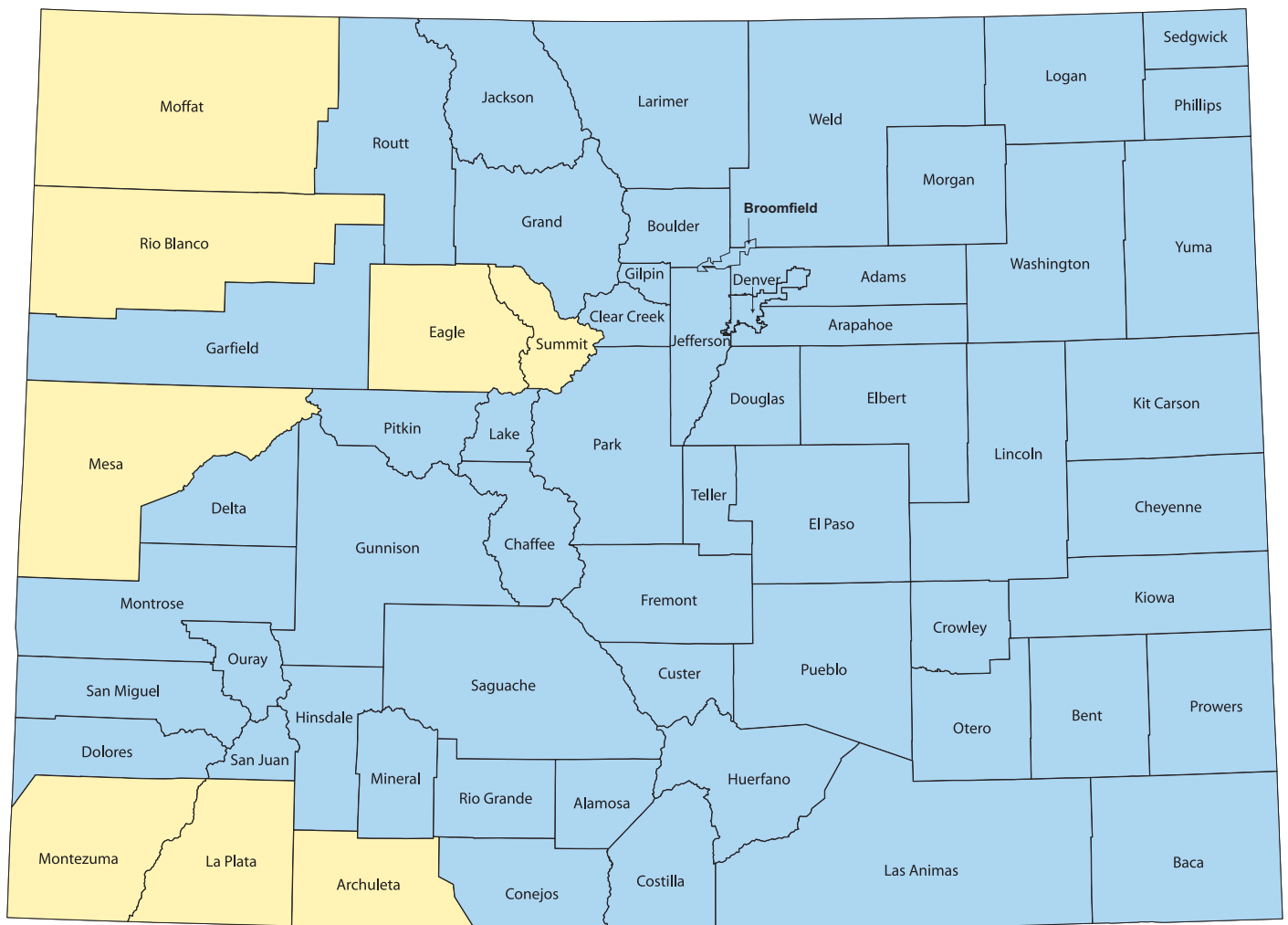
Colorado

Anthem Blue Cross and Blue Shield Individual Health Care Coverage Service Area Effective 1/1/2020

Not all HMO networks are available in all counties, check this map to see what is available in your area.* Pathway and Mountain Enhanced networks are offered on and off the Marketplace.

- = Pathway Only
- = Pathway & Mountain Enhanced

* While we make efforts to ensure that our lists of doctors, hospitals, and other providers are up to date and accurate, providers do leave our networks from time to time, and the listings included on *Find a Doctor* at anthem.com do change.



ONE NUMBER. ONE WEBSITE. ONE APP.

Your Anthem plan includes access to a Health Savings Account (HSA) to manage and pay for your care.

Wouldn't it be nice if your health plan was easy to use, access and understand? Your HSA plan gives you everything you need in a single, simple plan with just one debit card, website, phone number and mobile app. An HSA 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.

Four reasons you'll love your HSA plan. You'll have:

1



A debit card for your account. So it's easy to pay your out-of-pocket expenses for care.

2



One website for your benefits and spending account. You can:

- Check your HSA balance.
- Look for doctors, hospitals, facilities and other health care professionals.
- Review your claims, find out if you owe anything for care and pay your balance directly from your HSA online.
- See your benefit information, including deductible and out-of-pocket.
- Estimate the cost of care before you see a doctor.

3



One mobile app to download and use when you're on the go. With the Sydney app, you can:

- See all of your account and claims information.
- Take a photo of a receipt and upload it for reimbursement.
- Manage and send payments from your HSA.
- Find care wherever you are, 24/7.

4



One customer service phone number to call if you have questions about your plan or account.



Get real-time alerts for your HSA

Want to know if your balance is low, get confirmation of your deposit or if an account statement is available? Sign up for email or text message alerts at anthem.com so you'll know as soon as possible about updates to your HSA.

USING YOUR HSA

Open your HSA

Once you elect the HSA option, we will start the Consumer Identification Program (CIP). Under the Patriot Act, all financial institutions are required to confirm the identity of anyone opening a new account. Our banking partner will complete the CIP process and notify you if they need additional information. Once the CIP process is complete, your account will be opened. We use the information provided at enrollment to open your account and complete CIP. It is important that you enroll using your legal name to avoid delays in opening your account.

Welcome letter and debit card

Once your account is opened, you can log-on to [anthem.com](https://www.anthem.com) to see your account information at any time and learn more about your health plan, benefits and HSA. You will also receive a welcome letter and your debit card from us. A debit card is automatically issued to you and your spouse. If you need a debit card for any other dependents, you can order them on [anthem.com](https://www.anthem.com) or by calling member services at the number on the back of your ID card.

Transfer HSA funds

If you already have an HSA, you can make your life easier by transferring your funds to your new HSA.

- o **One account experience.** With your funds in one place, you will have one login, one statement, one mobile app, one support team, and one debit card.
- o **No unnecessary fees.** By consolidating funds and closing your other account, you eliminate account administration fees from your prior HSA custodian.
- o **Easier tax filings.** By having one HSA for the whole year, you will only have one set of tax forms to manage when it comes time to file your taxes.
- o **Increased investment opportunity.** By combining your accounts, you have the maximum opportunity to grow your savings for the future.

Once your account is open, visit [anthem.com](https://www.anthem.com) or call customer service at the number on the back of your ID card for more information. Please note that your prior HSA custodian may charge a fee to transfer and close your account.

This is what the IRS requires if you want to open a health savings account:

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

Note: You have the option of using a different financial institution to set up your Health Savings Account. However, you would be responsible for any HSA account related fees applied by the chosen financial institution.



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.^Δ

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](https://www.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”?

Access Health CT (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 Access Health CT.

To learn more, visit your state's exchange website at AccessHealthCt.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 Access Health CT. 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 off-exchange and on-exchange		Anthem Dental Family off-exchange and on-exchange	
	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	\$1,000	None	\$1,000
Annual out-of-pocket limit	\$350 ² / None	None	\$350 ² / None	None
Diagnostic and preventive	No waiting period	No waiting period	No waiting period	No waiting period
Cleaning, exams, x-rays	0% / 0% coinsurance	0% / 30% coinsurance	0% / 0% coinsurance	0% / 30% coinsurance
Basic services	No waiting period	6-month waiting period	No waiting period	6-month waiting period
Fillings	40% / 40% coinsurance	40% / 50% coinsurance	40% / 40% coinsurance	40% / 50% 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	Not covered	50% / 50% coinsurance	50% / 50% coinsurance
Prosthetics (crowns, dentures, bridges)	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	50% / 50% 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 With our Dental Family Enhanced plans, the deductible is waived for diagnostic and preventive services received in our network.

² Per child, up to \$700 per family.

Note: This is only a brief description of some plan benefits. Please refer to the Subscriber Agreement for more complete details including benefits, limitations and exclusions.

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 off-exchange and on-exchange		Dental Prime Plan A off-exchange only	Dental Prime Plan B off-exchange only	Dental Prime Plan C off-exchange only
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
\$60 ¹	\$60 ¹	None	\$50	\$50
None	\$2,000	\$500	\$1,000	\$1,250
\$350 ² / None	None	None	None	None
No waiting period	No waiting period	No waiting period	No waiting period	No waiting period
0% / 20% coinsurance	0% / 20% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance
No waiting period	6-month waiting period	Not covered	6-month waiting period	6-month waiting period
20% / 40% coinsurance	20% / 40% coinsurance	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
Not covered	Covered	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
No waiting period	12-month waiting period	Not covered	12-month waiting period	12-month waiting period
40% / 50% coinsurance	40% / 50% coinsurance	Not covered	50% / 50% coinsurance	50% / 50% coinsurance
40% / 50% coinsurance	40% / 50% coinsurance	Not covered	Not covered	50% / 50% coinsurance
50% / 50% coinsurance	Not covered	Not covered	Not covered	Not covered
Not covered	Not covered	Not covered	Not covered	Not covered
Included	Included	Included	Included	Included
Available	Available	Available	Available	Available

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.

Find a dentist

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

What's your monthly premium for the plan options above?

Take a look at our [monthly rates for a dental plan with a vision plan included](#).

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.

What's your monthly premium for Blue View Vision Enhanced, Plus and Value plans?

Take a look at **Blue View Vision Enhanced, Plus and Value monthly rates** now.

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	\$20	
Scratch coating	\$22	Included	N/A	\$0	
Progressive premium tier 1	\$140	Upgrade	N/A	\$85	
Polycarbonate lenses	\$55	Upgrade	N/A	\$40	
Anti-reflective premium tier 2	\$100	Upgrade	N/A	\$68	Member saves \$409
Transitions lenses	\$110	Upgrade	N/A	\$75	
Total purchase	\$717			\$308	

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! Take a look at the **application** included with this brochure.

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 (1-855-738-6644 / 1-855-837-8537). (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 (1-855-738-6644 / 1-855-837-8537). (TTY/TDD: 711)

Albanian

Nëse ju nevojitet ndihmë për ta kuptuar këtë dokument në një gjuhë tjetër, mund ta kërkonti pa kosto shtesë duke telefonuar në numrin e shërbimeve për anëtarët (1-855-738-6644 / 1-855-837-8537). (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. (1-855-738-6644 / 1-855-837-8537) (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(1-855-738-6644 / 1-855-837-8537)請求免費協助。(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 : 1-855-738-6644 / 1-855-837-8537. (TTY/TDD: 711)

Greek

Αν χρειαστείτε βοήθεια για να κατανοήσετε το παρόν έγγραφο σε άλλη γλώσσα, μπορείτε να τη ζητήσετε χωρίς πρόσθετο κόστος καλώντας τον αριθμό του Τμήματος Υπηρεσιών Μέλους (1-855-738-6644 / 1-855-837-8537). (TTY/TDD: 711)

Haitian

Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (1-855-738-6644 / 1-855-837-8537). (TTY/TDD: 711)

Hindi

अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (1-855-738-6644 / 1-855-837-8537) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

Italian

Se ha bisogno di assistenza per la comprensione del presente documento in un'altra lingua, può richiederla senza alcun costo aggiuntivo chiamando il numero dedicato ai Servizi per i membri (1-855-738-6644 / 1-855-837-8537). (TTY/TDD: 711)

Korean

다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(1-855-738-6644 / 1-855-837-8537)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Polish

Jeśli potrzebujesz pomocy w zrozumieniu niniejszego dokumentu w innym języku, możesz ją uzyskać bez ponoszenia dodatkowych kosztów, dzwoniąc do Działu Obsługi Klienta pod numer (1-855-738-6644 / 1-855-837-8537). (TTY/TDD: 711)

Portuguese-Europe

Se necessitar de ajuda para compreender este documento noutra idioma, poderá solicitá-la gratuitamente ligando para o número dos Serviços para Membros (1-855-738-6644 / 1-855-837-8537). (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 (1-855-738-6644 / 1-855-837-8537). (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 (1-855-738-6644 / 1-855-837-8537). (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 (1-855-738-6644 / 1-855-837-8537). (TTY/TDD: 711)



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 Subscriber Agreement 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.

△ 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.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc. Independent licensee 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 through December 31, 2020

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	\$6.89
Individual + one	\$12.05
Family	\$19.28



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, 2020

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	\$17.63	\$30.85	\$49.36
Blue View Vision Plus	\$13.80	\$24.16	\$36.85
Blue View Vision Value	\$11.43	\$20.01	\$32.01

* 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.

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.

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?

If you're working with an agent or broker, contact them first. Or go to [anthem.com](https://www.anthem.com). And if you have any questions, give us a call at 1-877-212-1793.



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](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 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 *Individual Colorado 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

With home delivery, you can get up to a 90-day supply of your maintenance medication 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, 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.





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 **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 access the **Rx Choice Tiered Network** pharmacy listing for Colorado.
- Learn more about your pharmacy benefits — including why some drugs need preapproval to be covered — by going to our frequently asked questions (FAQ) at [anthem.com/faqs/colorado/pharmacy](https://www.anthem.com/faqs/colorado/pharmacy).

On the go, too! All of the same helpful tools are available on your cellphone or other mobile device with the Sydney mobile app. You can manage your drug benefits wherever you are, whenever you need to.

Medical + pharmacy — better and easier than ever

With combined medical and pharmacy benefits, you'll receive more effective and affordable health care.

We do this by providing:

- Better management of chronic conditions.
- Improved health outcomes through care gap notifications.
- Connected, personal care for members who are taking specialty medications.
- Cost saving opportunities like lower cost generic drugs, home delivery, and the use of a broad network of retail pharmacies.

¹ Schwab P, Racska P, Rascati K, Mourer M, Meah Y, Worley K. A Retrospective Database Study Comparing Diabetes-related Medication Adherence and Health Outcomes for Mail-order versus Community Pharmacy. *J Manag Care Spec Pharm* 2019; Mar;25(3):332-40: [ncbi.nlm.nih.gov/pubmed/30816817](https://pubmed.ncbi.nlm.nih.gov/pubmed/30816817)