Colorado
PRODUCT GUIDE

Anthem

Connecting you to the right coverage

Medical

2023 Individual and Family Plans

CONNECT for HEALTH COLORADO®

Plans on the Marketplace

Bronze, Silver, Gold, and Catastrophic plans

Certified by Connect for Health Colorado®

Plans off the Marketplace

Bronze, Silver, and Catastrophic plans

Offered by Anthem Blue Cross and Blue Shield on anthem.com

Open enrollment period runs November 1, 2022 - January 15, 2023

1039738COMENABS 7/22

Helping you feel covered, protected, and confident

Whether you've had health coverage before or are new to this process, Anthem Blue Cross and Blue Shield is here to support you every step of the way — from helping you decide which individual plan makes sense for your unique needs to connecting you to the right doctor, resources, and financial help. We're committed to simplifying and caring for every aspect of your health, including medical, dental, vision, pharmacy, and mental health needs.

Finding an affordable plan

Let us help you find a plan that fits your needs and budget. Our plans include:

- Online doctor visits for $0.[1]
- 24/7 online doctor visits.
- Preventive care at $0.[2]
- Certain prescription drugs at $0, with cost-saving mail-order and supply options.[3]
- Predictable out-of-pocket costs for fewer surprises.

Health Insurance Marketplace plans

If you buy your health coverage through Connect for Health Colorado, it's considered a "Marketplace plan". If you buy your health coverage directly from an insurance company, it's considered an "off-Marketplace plan". These plans are sometimes referred to as plans on the exchange (on-exchange), or plans off the exchange (off-exchange).

Subsidies may be available for plans on the Marketplace, but are typically not available for plans off the Marketplace.
New SilverEnhanced Savings available on Colorado Connect.

Quick access to benefit charts

Learn more about **Marketplace** plan benefits.

Learn more about **off-Marketplace** plan benefits.

Learn more about **Colorado Connect** plan benefits.

1 Virtual care visits, including medical chats and video visits using the Sydney Health app are at no cost to members for most plans. Those enrolled in High-Deductible Health Plans associated with a Health Savings Account and Catastrophic plans must first meet their deductible. Virtual care visits refer to medical chats and/or video consultation, as deemed appropriate by a licensed physician. Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of Anthem Blue Cross and Blue Shield health plans. ©2020-2022. The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

2 Nationally recommended preventive care services received in-network have no copay and no deductible requirement.

3 Some commonly used prescription drugs are available at no cost to you. Contact us for more information.

Maximizing healthcare dollars

You may qualify for financial help to lower your costs

If you think coverage will be too costly, we can help you check to see if you qualify for a health insurance subsidy.

A subsidy is government financial help or tax credits to help lower your monthly costs. You may also qualify for a plan where you pay less out-of-pocket for health expenses.

Depending on your income, you may be eligible for coverage that costs as low as $0 to $1 a month.[1]

Based on our estimates, 9 out of 10 people will qualify for assistance.[2]

As your healthcare partner, we can help you:

- Find out if you're eligible for financial assistance.
- Estimate your possible savings with different plans.
- Choose a plan based on your needs and budget.
- Walk through the application process.

To learn more, go to **anthem.com**, **ConnectforHealthCO.com**, or visit **colorado-connect.com**.

Covering costs with a health savings account (HSA)

An HSA is a special account for tax-free contributions to help manage and pay for healthcare expenses like deductibles, coinsurance, and prescriptions.

Learn more about HSAs.

1 Based on federal and/or state exchange requirements and subject to change. Anthem Blue Cross and Blue Shield is a Qualified Health Plan issuer that in certain geographic areas offers some health plans with a $0 premium option (after subsidy applied) through the Health Insurance Marketplace or your State Exchange. Anthem health plans with a $0 premium option are not available in all areas and eligibility for these plans is based on federal annual income guidelines. Call us for information because not everyone will qualify. For example, singles earning up to $19,140, and couples earning up to $25,860 may be eligible. Family income eligibility varies based on number of family members.

2 Anthem Business Intelligence Analysis of 2021 WEM Application Data and FPL Distribution, May 2021.

Connecting benefits

Pharmacy

Our IngenioRx pharmacy solution is included with your medical plan for seamless care, offering:

- $0 for most commonly used medications.[1]
- 24/7 access to dedicated pharmacy experts.
- Digital features to price a medication, find a pharmacy in your plan, or refill a prescription online.

Two convenient ways to fill your prescription medicine:

Pharmacies

- For a 30-day supply of a covered medications, pharmacies in your plan include most national chains like CVS (including Target), Walmart, Costco, and Kroger.[2]
- Your plan also includes many independent pharmacies. Ninety-day supplies of covered medications also are available at certain retail pharmacies.
- The Rx Choice Tiered Network has more than 66,000 pharmacies nationwide, with two levels of coverage:[3]
  - **Level 1:** You will see the lowest cost for your prescriptions when you use one of the 26,000 Level 1 pharmacies. These include CVS, (including Target), Walmart, Kroger, and Costco.
  - **Level 2:** With a Level 2 pharmacy, your prescriptions will be covered, but you will pay a higher copay or coinsurance. There are 40,000 Level 2 pharmacies, including Walgreens and Rite Aid.

Home delivery

With IngenioRx home delivery, you can receive up to a 90-day supply of medications you take on a regular basis — delivered right to your door. For greater convenience and savings, you also receive free standard shipping on automatic refills.

Dental and vision

Pediatric dental and vision benefits are included with our medical plans. We also offer separate, stand-alone vision and dental plans for more complete coverage.

Learn more about pediatric dental and vision benefits included in your plan.

Learn more about additional **Marketplace** stand-alone dental benefits.

Learn more about additional **off-Marketplace** stand-alone dental and vision benefits.

Supplemental coverage

Budget-friendly supplemental insurance can provide extra protection to lessen the costs of unexpected events like an accident or critical illness. Call **888-811-2101**, 6:30 a.m. to 6:00 p.m. MT, or visit **anthem.com**.[4]

1 Some commonly used prescription drugs are available at no cost to you. Contact us for more information.

2 IngenioRx data, 2020.

3 All Colorado Option Standard Plans offer the Rx Base network. See page 10 for more information on Colorado Option Standard plans.

4 Anthem Blue Cross and Blue Shield does not underwrite, insure, or administer the Personal Accident, Critical Illness, and Hospital Recovery insurance plans. LifeSecure Insurance Company (Brighton, MI) underwrites and has sole financial responsibility for the Personal Accident, Critical Illness, and Hospital Recovery insurance products. LifeSecure is an independent company that does not provide Anthem Blue Cross and Blue Shield products or services. Product cost and availability will vary based on the consumer's state and age. These products are not qualifying health coverage (Minimum Essential Coverage) that satisfies the health coverage requirement of the Affordable Care Act and have limitations and exclusions. The termination or loss of any of these policies does not entitle the client to a special enrollment period to purchase a health benefit plan that qualifies as minimum essential coverage outside of an open enrollment period.

Network and costs

Finding care

With our Find Care tool, you can:

- Search for providers near you by name, specialty, or procedure.
- Compare doctor quality ratings.
- Look at provider details, such as their specialties, languages spoken, office locations, and if they're accepting new patients.
- Compare costs.
- Explore online care options.

Doctors and hospitals don't all charge the same price for the same service. That's why Find Care helps you compare costs for common healthcare services before you make big decisions. Estimates are based on what your plan covers, so you see a true picture of what you would pay.

You can access Find Care on **anthem.com**, through the Sydney℠ Health mobile app, or using the Anthem Skill for Amazon Alexa.

Wondering if a doctor is in our network?

You can follow these easy steps to check:[1]

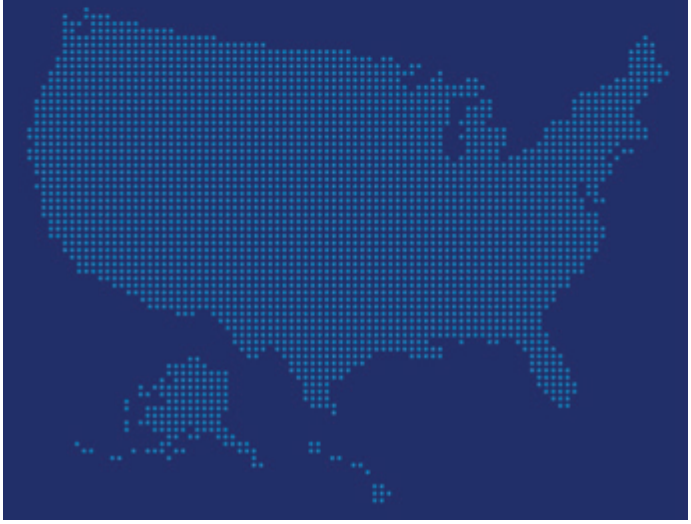
1. Go to **anthem.com** and choose **Find Care**.
2. Scroll to and select **Select a plan for basic search**.
3. Under *What type of care are you searching for?*, choose **Medical**.
4. Select the state you want to search in.
5. Under *What type of plan do you want to search with?*, choose **Medical (Individuals and Families)**.
6. Under *Select a plan/network*, pick your plan.
7. Select **Search** to look for a doctor by name or location.
8. Enter your ZIP code and complete the *Search for care by specialty, name, National Provider Identifier, or license number*.

BlueCard: Protecting yourself out of state

As a member, you have access to emergency and urgent care nationwide through the BlueCard® program and internationally through the Blue Cross Blue Shield Global Core® program.

When you are out of Colorado for work, school, or vacation, you shouldn't have to worry about health surprises. That's why our health maintenance organization (HMO) plans cover medically necessary emergency and urgent care in all 50 states and worldwide.

Anthem's national network includes **1.7 million doctors and hospitals** — more than any other insurer.[2]



1 We strive to ensure our provider lists are as accurate as possible. It's important to confirm doctor is in your plan.

2 Blue Cross Blue Shield Association, Blue Facts (accessed March 2022): bcbs.com.

Earning rewards for healthy habits

Our Smart Rewards program lets you and your covered spouse or partner earn rewards for completing health and wellness activities. You can redeem the rewards for a digital gift card from a selection of top retailers.[1,2]

Visiting your doctor for an annual wellness or well-woman exam within the first 90 days of your plan's start date.	**$25**
Completing the digital Health Assessment.	**$20**

Getting a little help can go a long way

As a member, you can access various tools and resources throughout your healthcare journey. These include:

- **24/7 NurseLine:** Registered nurses answer your health questions by phone, day or night.
- **Care Support:** Case managers offer guidance in managing any ongoing or complex health issues.
- **MyHealth Advantage:** We track your claims to see if there are care gaps or ways to save you money. If we find anything, we mail you a confidential MyHealth Note.

SpecialOffers: member discounts that make a difference

With SpecialOffers℠, you can take advantage of discounts on health-related products and services, like weight-loss coaching, contact lenses, and fitness club memberships.[3] It's another way we can support your health goals.

1 The list of retailers available for electronic gift card rewards redemption is subject to change. Once a claim is processed, typically 60 days after the date of service, you'll be able to see confirmation of the reward, which can be found on anthem.com or Sydney Health under the My Health Dashboard, My Rewards page. Any rewards earned must be redeemed before the end of the current year. Unused rewards are forfeited, and your reward balance will reset to zero at the beginning of the new plan year.

2 The amount of the reward may be considered income to you and subject to state and federal taxes in the tax year it is paid. We recommend you consult a tax expert with any questions regarding your tax obligations.

3 SpecialOffers discounts are subject to change without notice.

Sydney Health app

Keeping all your health information in one place

The Sydney Health mobile app helps you navigate your healthcare experience, including one-step access to benefits information, Member Services, virtual care visits, and an interactive chat feature.

With the Sydney Health mobile app, you can:

- Check benefit information and claim details.
- Compare costs for healthcare services.
- Search for doctors, care centers, pharmacies, and hospitals in your plan.
- Set up online visits with doctors, psychologists, and therapists.
- Use the Symptom Assessment tool.
- Access your digital ID card.

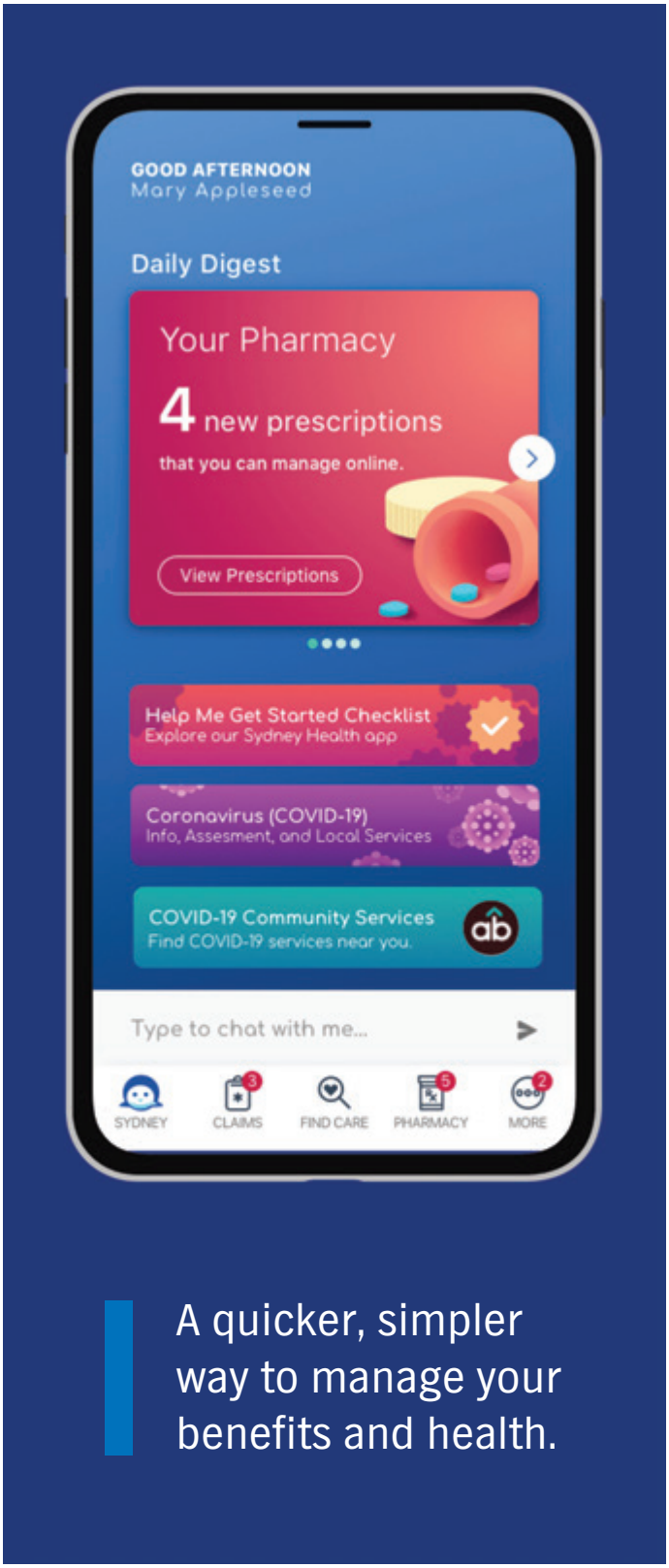
Sydney Health is available on the App Store® or Google Play™, and works with Amazon Alexa.

Virtual doctor visits with Sydney Health

The Sydney Health mobile app can connect you to care anytime, often at low or no-additional cost to you.

If you or a covered family member has a health issue like the flu or allergies, you can quickly see a doctor for quality care using a smartphone, tablet, or computer with a camera.[1]

You can also have a virtual care visit with a licensed therapist for stress, anxiety, depression, family issues, and other behavioral health concerns. Psychiatrists are available by appointment when needed.[2]



1 Virtual care visits, including medical chats and video visits using the Sydney Health mobile app, are at no cost to members for most plans. Those enrolled in high-deductible health plans associated with a health savings account and Catastrophic plans must first meet their deductible. Virtual care visits refer to medical chats and/or video consultation, as deemed appropriate by a licensed physician.

2 Appointments are subject to the availability of a therapist. Online counseling is not appropriate for all problems. If you are in crisis or having suicidal thoughts, it is important that you seek help immediately. Please call the National Suicide Prevention Lifeline at 800-273-TALK (1-800-273-8255), or 911 for help. If it is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield health plans.

Understanding ACA metal levels

The Affordable Care Act (ACA) uses metal levels to categorize plans. When you're trying to decide on the best metal level for you, consider how much coverage you want, your expenses for the coming year, and what you can afford.

If you need help figuring out the right fit for your needs and budget, contact Anthem to discuss each option.

We also offer **Catastrophic** plans, which are designed to help people in a serious health crisis find low-cost coverage. It has certain restrictions, including age.[1]

To learn more, please look at the chart below:

Level	Costs covered[2]	Good fit if you need:
Bronze	60% You Pay: 40%	Routine checkups and preventive care.
Silver	70% You Pay: 30%	Routine preventive care along with coverage for a condition or upcoming procedure.
Gold	80% You Pay: 20%	Routine preventive care and an upcoming procedure where you need to pay a lower share of the costs.

1 **Catastrophic** is a high-deductible, low monthly payment option to protect you during serious health crises. To qualify for this coverage level, you have to be under 30 years of age or 30 years of age or older with an approved hardship exemption from healthcare.gov.

2 Estimated averages for a typical population. Your costs will vary.

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 of Coverage (Coverage) may be continued in force or discontinued. To see complete details on what is covered and what is not:

- Review the Certificate.
- Call your broker or Anthem representative.
- Go to anthem.com.

To view a copy of both a ***Summary of Benefits and Coverage (SBC)*** and the ***CO SBC Supplement***, please visit **sbc.anthem.com** and select **NEXT** for Summaries in English or Spanish. Other language links are listed on the SBC page below *NEXT*.

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

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

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

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

We're proud that
43 million Americans
carry a Blue-branded card accepted by healthcare providers nationwide.*

* Blue Cross Blue Shield Association, *Blue Facts* (accessed January 2020); bcbs.com

Colorado Option Standard Health Benefit plans

Standard health benefit plans are state-mandated plans defined by the Division of Insurance (DOI) that all carriers participating in the market must offer. These standard plans have the same benefits and cost-sharing for many types of care among all carriers.

Standard plans allow consumers to compare plans more easily across carriers. Since the plan designs are the same; quality, network, and price will be differentiating factors across insurance companies. Carriers will offer these plans with different networks and at different premiums, allowing consumers to shop based on network and premium. Additionally, the Colorado Option Standard plan benefits, networks, and cost shares may change every year based on regulations issued by the DOI or public hearings regarding which providers must participate in such plans, and what reimbursement rates.

- Available on the Pathway Standard, Pathway Essentials Standard, and Mountain Enhanced Standard HMO networks.
- Pathway Standard, Pathway Essentials Standard, and Mountain Enhanced Standard HMO networks may have different out-of-area coverage.

View our county network coverage map **here**.

Colorado Option Standard Health Benefit plans are available through **Connect for Health Colorado®**, **Colorado Connect**, and **Anthem** directly.

You may qualify for financial help in 2023 even if you didn't before. You may be eligible for additional assistance through Connect for Health Colorado.

Open enrollment period runs **November 1, 2022 - January 15, 2023**

Reimagining what's possible for every moment of care

We know finding a plan that works for you and your loved ones is a big decision. With Anthem you're never alone for the important choices.

Get started today

- Call us at **888-811-2101**, 6:30 a.m. to 6:00 p.m. MT or contact your broker.
- Visit **anthem.com**, select **Individual and Family**, and apply online.
- For off-Marketplace plans, review the **application** included with this brochure.
- Find Marketplace plans through Connect for Health Colorado at **ConnectforHealthCO.com**.

Let us connect you to the right individual coverage.

Qualifying life events

If you experience a major life event, you may need to make plan changes outside the sign-up period. To see if your life event qualifies for a plan change, call us at **888-811-2101** or contact your broker.

You can buy health plans once a year during open enrollment.
For 2023, this period runs from **November 1, 2022 - January 15, 2023. Dates may change and vary by state.**

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

Printed kits available from your broker upon request.

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Colorado
BENEFIT CHART

Anthem

Medical

Benefit Charts

2023 Individual and Family Plans

Plans off the Marketplace

Bronze, Silver, and Catastrophic plans

Offered by Anthem Blue Cross and Blue Shield on anthem.com

Open enrollment period runs November 1, 2022 - January 15, 2023

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Helping you feel covered, protected, and confident

Whether you've had health coverage before or are new to this process, we're here to support you every step of the way—from helping you decide which individual plan makes sense for your unique needs to connecting you to the right doctor, resources, and financial help.

We're committed to simplifying and caring for every aspect of your health, including medical, dental, vision, pharmacy, and mental health needs.

The following pages contain plan benefit charts along with terms you need to know when selecting a health plan. This information will help you understand commonly used insurance words and assist you in selecting the right coverage for your needs and budget.

▷ Let us connect you to the right individual coverage.

Product Overview

Understanding Provider Networks

When choosing a plan, you will have access to a specific network. Certain networks may be larger than others or offer different options for local providers. It's important to understand these differences and keep your healthcare needs in mind when choosing a plan.

Pathway HMO/Pathway Standard HMO, Pathway Essentials/Pathway Essentials Standard, Mountain Enhanced/Mountain Enhanced Standard networks:

With these health maintenance organizations (HMOs), you pick a primary care physician (PCP). This is your doctor for preventive care, such as yearly checkups, screenings and vaccinations, health problems, or support reaching your health goals. You can also see specialty doctors, like dermatologists and allergists, without a referral if they are in the plan network.

If there's a medical emergency, go to the nearest hospital or urgent care. Whether received in or out of network, these plans help pay for medically necessary emergency and urgent care services, or when a service is preapproved.

Colorado Option Standard Health Benefit plans:

Standard health benefit plans are state-mandated plans defined by the Division of Insurance (DOI) that all carriers participating in the market must offer. These standard plans have the same benefits and cost-sharing for many types of care among all carriers.

Standard plans allow consumers to compare plans more easily across carriers. Since the plan designs are the same; quality, network, and price will be differentiating factors across insurance companies. Carriers will offer these plans with different networks and at different premiums, allowing consumers to shop based on network and premium. Additionally, the Colorado Option Standard plan benefits, networks, and cost shares may change every year based on regulations issued by the DOI or public hearings regarding which providers must participate in such plans, and what reimbursement rates.

- Available on the Pathway Standard, Pathway Essentials Standard, and Mountain Enhanced Standard HMO networks.
- Pathway Standard, Pathway Essentials Standard, and Mountain Enhanced Standard HMO networks may have different out-of-area coverage.

Colorado Option Standard Health Benefit plans are available through **Connect for Health Colorado®**, **Colorado Connect**, and **Anthem** directly.

You may qualify for financial help in 2023 even if you didn't before. You may be eligible for additional assistance through Connect for Health Colorado.

View our county network coverage map here.

Plan benefit charts — HMO

Pathway HMO is offered in all counties. **Pathway Essentials** offered in Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, and Park counties. **Mountain Enhanced** offered in Archuleta, Eagle, La Plata, Mesa, Moffat, Montezuma, Rio Blanco, Routt, and Summit counties.

Plan name	Anthem Bronze Mountain Enhanced HMO 5650 Rx Copay $0 Select Drugs (6RTH)	Anthem Bronze Mountain Enhanced HMO 6000 $0 Select Drugs (6RWX)	Anthem Bronze Mountain Enhanced HMO 7450 for HSA (6RWU)	Anthem Bronze Mountain Enhanced HMO 9100 $0 Select Drugs (6RU2)	Anthem Bronze Pathway HMO 5650 Rx Copay $0 Select Drugs (6RWA)	Anthem Bronze Pathway HMO 6000 $0 Select Drugs (6RUH)	Anthem Bronze Pathway HMO 7450 for HSA (6RWW)
Network name	Mountain Enhanced	Mountain Enhanced	Mountain Enhanced	Mountain Enhanced	Pathway	Pathway	Pathway
Plan includes out-of-network coverage?	No	No	No	No	No	No	No
Individual deductible	$5,650	$6,000	$7,450	$9,100	$5,650	$6,000	$7,450
Individual out-of-pocket maximum	$9,100	$9,100	$7,450	$9,100	$9,100	$9,100	$7,450
Coinsurance (percentage may vary for certain covered services)	40%	30%	0%	0%	40%	30%	0%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office (in person or online) visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$50 copay per visit for first 2 visits, then deductible and 40% coinsurance	$45 copay per visit for first 3 visits, then deductible and 30% coinsurance	Deductible, then covered in full	$50 copay per visit for first 3 visits, then deductible and 0% coinsurance	$50 copay per visit for first 2 visits, then deductible and 40% coinsurance	$45 copay per visit for first 3 visits, then deductible and 30% coinsurance	Deductible, then covered in full
Virtual visit from our online provider: LiveHealth Online	Covered in full	Covered in full	Deductible, then covered in full	Covered in full	Covered in full	Covered in full	Deductible, then covered in full
Medical chat and virtual visit for primary care from our online provider: K Health	Covered in full	Covered in full	Deductible, then covered in full	Covered in full	Covered in full	Covered in full	Deductible, then covered in full
Office and online visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $250 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then $250 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then covered in full
Urgent care (Other office services may be subject to deductible and plan coinsurance)	$75 copay	$75 copay	Deductible, then covered in full	Deductible, then covered in full	$75 copay	$75 copay	Deductible, then covered in full
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then $300 copay and 40% coinsurance	Deductible, then $300 copay and 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then $300 copay and 40% coinsurance	Deductible, then $300 copay and 30% coinsurance	Deductible, then covered in full
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 covered in full	Deductible, then covered in full	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then covered in full
Hospital: outpatient surgery hospital facility (includes maternity, mental health/substance use)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full
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	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	Level 1 / Level 2 Pharmacy Tiers 1,2,3,4: Medical deductible applies
Retail pharmacy tier 1: Level 1 / Level 2	$30 copay / $45 copay	30% coinsurance / 45% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	$30 copay / $45 copay	30% coinsurance / 45% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2: Level 1 / Level 2	$75 copay / $90 copay	30% coinsurance / 45% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	$75 copay / $90 copay	30% coinsurance / 45% 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	0% coinsurance / 0% coinsurance	$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	0% coinsurance / 0% coinsurance	$650 copay / $660 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance
Physical and occupational therapy[2] (limits apply)	$50 copay per visit for first 2 visits, then deductible and 40% coinsurance	$45 copay per visit for first 3 visits, then deductible and 30% coinsurance	Deductible, then covered in full	$50 copay per visit for first 3 visits, then deductible and 0% coinsurance	$50 copay per visit for first 2 visits, then deductible and 40% coinsurance	$45 copay per visit for first 3 visits, then deductible and 30% coinsurance	Deductible, then covered in full
Speech therapy[2] (limits apply)	$50 copay per visit for first 2 visits, then deductible and 40% coinsurance	$45 copay per visit for first 3 visits, then deductible and 30% coinsurance	Deductible, then covered in full	$50 copay per visit for first 3 visits, then deductible and 0% coinsurance	$50 copay per visit for first 2 visits, then deductible and 40% coinsurance	$45 copay per visit for first 3 visits, then deductible and 30% coinsurance	Deductible, then covered in full

Please see Medical plans footnotes on page 9.

Plan benefit charts

Pathway HMO is offered in all counties. **Pathway Essentials** offered in Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, and Park counties. **Mountain Enhanced** offered in Archuleta, Eagle, La Plata, Mesa, Moffat, Montezuma, Rio Blanco, Routt, and Summit counties.

Plan name	Anthem Bronze Pathway HMO 9100 $0 Select Drugs (6RWC)	Anthem Bronze Pathway Essentials HMO 5650 Rx Copay $0 Select Drugs (6RVE)	Anthem Bronze Pathway Essentials HMO 6000 $0 Select Drugs (6RTM)	Anthem Bronze Pathway Essentials HMO 7450 for HSA (6RUZ)	Anthem Bronze Pathway Essentials HMO 9100 $0 Select Drugs (6RUF)	Anthem Silver Mountain Enhanced HMO 2800 30% $0 Select Drugs (6RUG)	Anthem Silver Mountain Enhanced HMO 3000 for HSA 20% (6SBW)
Network name	Pathway	Pathway Essentials	Pathway Essentials	Pathway Essentials	Pathway Essentials	Mountain Enhanced	Mountain Enhanced
Plan includes out-of-network coverage?	No	No	No	No	No	No	No
Individual deductible	$9,100	$5,650	$6,000	$7,450	$9,100	$2,800	$3,000
Individual out-of-pocket maximum	$9,100	$9,100	$9,100	$7,450	$9,100	$9,100	$6,400
Coinsurance (percentage may vary for certain covered services)	0%	40%	30%	0%	0%	30%	20%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office (in person or online) visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$50 copay per visit for first 3 visits, then deductible and 0% coinsurance	$50 copay per visit for first 2 visits, then deductible and 40% coinsurance	$45 copay per visit for first 3 visits, then deductible and 30% coinsurance	Deductible, then covered in full	$50 copay per visit for first 3 visits, then deductible and 0% coinsurance	$10 copay	Deductible, then 20% coinsurance
Virtual visit from our online provider: LiveHealth Online	Covered in full	Covered in full	Covered in full	Deductible, then covered in full	Covered in full	Covered in full	Deductible, then covered in full
Medical chat and virtual visit for primary care from our online provider: K Health	Covered in full	Covered in full	Covered in full	Deductible, then covered in full	Covered in full	Covered in full	Deductible, then covered in full
Office and online visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then covered in full	Deductible, then $250 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then $250 copay and 30% coinsurance	Deductible, then $500 copay and 40% coinsurance
Urgent care (Other office services may be subject to deductible and plan coinsurance)	Deductible, then covered in full	$75 copay	$75 copay	Deductible, then covered in full	Deductible, then covered in full	$75 copay	Deductible, then 20% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then covered in full	Deductible, then $300 copay and 40% coinsurance	Deductible, then $300 copay and 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then $350 copay and 30% coinsurance	Deductible, then $500 copay and 20% coinsurance
Hospital: inpatient admission (includes maternity, mental health/substance use)	Deductible, then covered in full	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then $500 copay and 30% coinsurance	Deductible, then $500 copay and 40% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health/substance use)	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 30% coinsurance	Deductible, then 20% 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	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	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 / $45 copay	30% coinsurance / 45% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	30% coinsurance / 45% coinsurance	20% coinsurance / 35% coinsurance
Retail pharmacy tier 2: Level 1 / Level 2	0% coinsurance / 0% coinsurance	$75 copay / $90 copay	30% coinsurance / 45% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	30% coinsurance / 45% coinsurance	20% coinsurance / 35% coinsurance
Retail pharmacy tier 3: Level 1 / Level 2	0% coinsurance / 0% coinsurance	$150 copay / $160 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	30% coinsurance / 50% coinsurance	30% coinsurance / 40% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	0% coinsurance / 0% coinsurance	$650 copay / $660 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	30% coinsurance / 50% coinsurance	30% coinsurance / 50% coinsurance
Physical and occupational therapy[2] (limits apply)	$50 copay per visit for first 3 visits, then deductible and 0% coinsurance	$50 copay per visit for first 2 visits, then deductible and 40% coinsurance	$45 copay per visit for first 3 visits, then deductible and 30% coinsurance	Deductible, then covered in full	$50 copay per visit for first 3 visits, then deductible and 0% coinsurance	$10 copay	Deductible, then 20% coinsurance
Speech therapy[2] (limits apply)	$50 copay per visit for first 3 visits, then deductible and 0% coinsurance	$50 copay per visit for first 2 visits, then deductible and 40% coinsurance	$45 copay per visit for first 3 visits, then deductible and 30% coinsurance	Deductible, then covered in full	$50 copay per visit for first 3 visits, then deductible and 0% coinsurance	$10 copay	Deductible, then 20% coinsurance

Please see Medical plans footnotes on page 9.

Plan benefit charts

Pathway HMO is offered in all counties. **Pathway Essentials** offered in Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, and Park counties. **Mountain Enhanced** offered in Archuleta, Eagle, La Plata, Mesa, Moffat, Montezuma, Rio Blanco, Routt, and Summit counties.

Plan name	Anthem Silver Mountain Enhanced HMO 3500 Rx Copay 15% $0 Select Drugs (6RTS)	Anthem Silver Mountain Enhanced HMO 5000 35% $0 Select Drugs (6RWQ)	Anthem Silver Mountain Enhanced HMO 6500 Rx Copay 40% $0 Select Drugs (6RW8)	Anthem Silver Pathway HMO 2800 30% $0 Select Drugs (6RVR)	Anthem Silver Pathway HMO 3000 for HSA 20% (6SC1)	Anthem Silver Pathway HMO 3500 Rx Copay 15% $0 Select Drugs (6RTU)	Anthem Silver Pathway HMO 5000 35% $0 Select Drugs (6RUU)
Network name	Mountain Enhanced	Mountain Enhanced	Mountain Enhanced	Pathway	Pathway	Pathway	Pathway
Plan includes out-of-network coverage?	No	No	No	No	No	No	No
Individual deductible	$3,500	$5,000	$6,500	$2,800	$3,000	$3,500	$5,000
Individual out-of-pocket maximum	$9,100	$7,500	$7,000	$9,100	$6,400	$9,100	$7,500
Coinsurance (percentage may vary for certain covered services)	15%	35%	40%	30%	20%	15%	35%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office (in person or online) visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$45 copay per visit for first 3 visits, then deductible and 15% coinsurance	$35 copay	$40 copay	$10 copay	Deductible, then 20% coinsurance	$45 copay per visit for first 3 visits, then deductible and 15% coinsurance	$35 copay
Virtual visit from our online provider: LiveHealth Online	Covered in full	Covered in full	Covered in full	Covered in full	Deductible, then covered in full	Covered in full	Covered in full
Medical chat and virtual visit for primary care from our online provider: K Health	Covered in full	Covered in full	Covered in full	Covered in full	Deductible, then covered in full	Covered in full	Covered in full
Office and online visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $500 copay and 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then $500 copay and 50% coinsurance	Deductible, then $250 copay and 30% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then $500 copay and 15% coinsurance	Deductible, then 35% coinsurance
Urgent care (Other office services may be subject to deductible and plan coinsurance)	$75 copay	$80 copay	$75 copay	$75 copay	Deductible, then 20% coinsurance	$75 copay	$80 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 35% coinsurance	Deductible, then $600 copay and 40% coinsurance	Deductible, then $350 copay and 30% coinsurance	Deductible, then $500 copay and 20% coinsurance	Deductible, then $500 copay and 15% coinsurance	Deductible, then 35% coinsurance
Hospital: inpatient admission (includes maternity, mental health/substance use)	Deductible, then $500 copay and 30% coinsurance	Deductible, then 35% coinsurance	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then 35% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health/substance use)	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1,2,3,4: No deductible	Level 1 / Level 2 Pharmacy Tiers 1,2: No deductible Tiers 3,4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1,2,3,4: 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	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	$5 copay / $15 copay	$5 copay / $15 copay	$5 copay / $15 copay	30% coinsurance / 45% coinsurance	20% coinsurance / 35% coinsurance	$5 copay / $15 copay	$5 copay / $15 copay
Retail pharmacy tier 2: Level 1 / Level 2	$50 copay / $65 copay	$40 copay / $50 copay	$40 copay / $50 copay	30% coinsurance / 45% coinsurance	20% coinsurance / 35% coinsurance	$50 copay / $65 copay	$40 copay / $50 copay
Retail pharmacy tier 3: Level 1 / Level 2	$80 copay / $90 copay	35% coinsurance / 50% coinsurance	$80 copay / $90 copay	30% coinsurance / 50% coinsurance	30% coinsurance / 40% coinsurance	$80 copay / $90 copay	35% coinsurance / 50% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	$650 copay / $650 copay	50% coinsurance / 50% coinsurance	$650 copay / $660 copay	30% coinsurance / 50% coinsurance	30% coinsurance / 50% coinsurance	$650 copay / $650 copay	50% coinsurance / 50% coinsurance
Physical and occupational therapy[2] (limits apply)	$45 copay per visit for first 3 visits, then deductible and 15% coinsurance	$35 copay	$40 copay	$10 copay	Deductible, then 20% coinsurance	$45 copay per visit for first 3 visits, then deductible and 15% coinsurance	$35 copay
Speech therapy[2] (limits apply)	$45 copay per visit for first 3 visits, then deductible and 15% coinsurance	$35 copay	$40 copay	$10 copay	Deductible, then 20% coinsurance	$45 copay per visit for first 3 visits, then deductible and 15% coinsurance	$35 copay

Please see Medical plans footnotes on page 9.

Plan benefit charts

Pathway HMO is offered in all counties. **Pathway Essentials** offered in Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, and Park counties. **Mountain Enhanced** offered in Archuleta, Eagle, La Plata, Mesa, Moffat, Montezuma, Rio Blanco, Routt, and Summit counties.

Plan name	Anthem Silver Pathway HMO 6500 Rx Copay 40% $0 Select Drugs (6RUB)	Anthem Silver Pathway Essentials HMO 2800 30% $0 Select Drugs (6RT1)	Anthem Silver Pathway Essentials HMO 3000 for HSA 20% (6SBD)	Anthem Silver Pathway Essentials HMO 3500 Rx Copay 15% $0 Select Drugs (6RVW)	Anthem Silver Pathway Essentials HMO 5000 35% $0 Select Drugs (6RV7)	Anthem Silver Pathway Essentials HMO 6500 Rx Copay 40% $0 Select Drugs (6RUS)	Anthem Catastrophic Pathway HMO 9100 (6RU3)
Network name	Pathway	Pathway Essentials	Pathway Essentials	Pathway Essentials	Pathway Essentials	Pathway Essentials	Pathway
Plan includes out-of-network coverage?	No	No	No	No	No	No	No
Individual deductible	$6,500	$2,800	$3,000	$3,500	$5,000	$6,500	$9,100
Individual out-of-pocket maximum	$7,000	$9,100	$6,400	$9,100	$7,500	$7,000	$9,100
Coinsurance (percentage may vary for certain covered services)	40%	30%	20%	15%	35%	40%	0%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office (in person or online) visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$40 copay	$10 copay	Deductible, then 20% coinsurance	$45 copay per visit for first 3 visits, then deductible and 15% coinsurance	$35 copay	$40 copay	$40 copay per visit for first 3 visits, then deductible and 0% coinsurance
Virtual visit from our online provider: LiveHealth Online	Covered in full	Covered in full	Deductible, then covered in full	Covered in full	Covered in full	Covered in full	Deductible, then covered in full
Medical chat and virtual visit for primary care from our online provider: K Health	Covered in full	Covered in full	Deductible, then covered in full	Covered in full	Covered in full	Covered in full	Deductible, then covered in full
Office and online visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then covered in full
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then covered in full
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $500 copay and 50% coinsurance	Deductible, then $250 copay and 30% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then $500 copay and 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then $500 copay and 50% coinsurance	Deductible, then covered in full
Urgent care (Other office services may be subject to deductible and plan coinsurance)	$75 copay	$75 copay	Deductible, then 20% coinsurance	$75 copay	$80 copay	$75 copay	Deductible, then covered in full
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then $600 copay and 40% coinsurance	Deductible, then $350 copay and 30% coinsurance	Deductible, then $500 copay and 20% coinsurance	Deductible, then $500 copay and 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then $600 copay and 40% coinsurance	Deductible, then covered in full
Hospital: inpatient admission (includes maternity, mental health/substance use)	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then 35% coinsurance	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then covered in full
Hospital: outpatient surgery hospital facility (includes maternity, mental health/substance use)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then covered in full
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	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 1,2,3,4: No deductible	Level 1 / Level 2 Pharmacy Tiers 1,2,3,4: Medical deductible applies
Retail pharmacy tier 1: Level 1 / Level 2	$5 copay / $15 copay	30% coinsurance / 45% coinsurance	20% coinsurance / 35% coinsurance	$5 copay / $15 copay	$5 copay / $15 copay	$5 copay / $15 copay	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2: Level 1 / Level 2	$40 copay / $50 copay	30% coinsurance / 45% coinsurance	20% coinsurance / 35% coinsurance	$50 copay / $65 copay	$40 copay / $50 copay	$40 copay / $50 copay	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3: Level 1 / Level 2	$80 copay / $90 copay	30% coinsurance / 50% coinsurance	30% coinsurance / 40% coinsurance	$80 copay / $90 copay	35% coinsurance / 50% coinsurance	$80 copay / $90 copay	0% coinsurance / 0% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	$650 copay / $660 copay	30% coinsurance / 50% coinsurance	30% coinsurance / 50% coinsurance	$650 copay / $650 copay	50% coinsurance / 50% coinsurance	$650 copay / $660 copay	0% coinsurance / 0% coinsurance
Physical and occupational therapy[2] (limits apply)	$40 copay	$10 copay	Deductible, then 20% coinsurance	$45 copay per visit for first 3 visits, then deductible and 15% coinsurance	$35 copay	$40 copay	Deductible, then covered in full
Speech therapy[2] (limits apply)	$40 copay	$10 copay	Deductible, then 20% coinsurance	$45 copay per visit for first 3 visits, then deductible and 15% coinsurance	$35 copay	$40 copay	Deductible, then covered in full

Please see Medical plans footnotes on page 9.

Plan benefit charts

Pathway HMO is offered in all counties. **Pathway Essentials** offered in Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, and Park counties. **Mountain Enhanced** offered in Archuleta, Eagle, La Plata, Mesa, Moffat, Montezuma, Rio Blanco, Routt, and Summit counties.

Plan name	Anthem Catastrophic Pathway Essentials HMO 9100 (6RTT)
Network name	Pathway Essentials
Plan includes out-of-network coverage?	No
Individual deductible	$9,100
Individual out-of-pocket maximum	$9,100
Coinsurance (percentage may vary for certain covered services)	0%
Preventive care[1]	No additional cost to you.
Office (in person or online) visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$40 copay per visit for first 3 visits, then deductible and 0% coinsurance
Virtual visit from our online provider: LiveHealth Online	Deductible, then covered in full
Medical chat and virtual visit for primary care from our online provider: K Health	Deductible, then covered in full
Office and online visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then covered in full
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then covered in full
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then covered in full
Urgent care (Other office services may be subject to deductible and plan coinsurance)	Deductible, then covered in full
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then covered in full
Hospital: inpatient admission (includes maternity, mental health/substance use)	Deductible, then covered in full
Hospital: outpatient surgery hospital facility (includes maternity, mental health/substance use)	Deductible, then covered in full
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 covered in full
Speech therapy[2] (limits apply)	Deductible, then covered in full

Please see Medical plans footnotes on page 9.

Plan benefit charts

Pathway Standard is offered in all counties except Adams, Arapahoe, Archuleta, Boulder, Broomfield, Clear Creek, Denver, Douglas, Eagle, Elbert, Gilpin, Jefferson, La Plata, Mesa, Moffat, Montezuma, Park, Rio Blanco, Routt, and Summit counties. **Mountain Enhanced Standard** plans are offered in Archuleta, Eagle, La Plata, Mesa, Moffat, Montezuma, Rio Blanco, Routt, and Summit counties.

Pathway Essentials Standard is offered in Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, and Park counties.

Plan name	Anthem Colorado Option Bronze Mountain Enhanced Std (6SBS)	Anthem Colorado Option Bronze Pathway Std (6SCL)	Anthem Colorado Option Bronze Pathway Essentials Std (6SCW)	Anthem Colorado Option Silver Mountain Enhanced Std (71LV)	Anthem Colorado Option Silver Pathway Std (71LU)	Anthem Colorado Option Silver Pathway Essentials Std (71LY)
Network name	Mountain Enhanced Standard	Pathway Standard	Pathway Essentials Standard	Mountain Enhanced Standard	Pathway Standard	Pathway Essentials Standard
Plan includes out-of-network coverage?	No	No	No	No	No	No
Individual deductible	$7,000	$7,000	$7,000	$5,000	$5,000	$5,000
Individual out-of-pocket maximum	$9,100	$9,100	$9,100	$8,550	$8,550	$8,550
Coinsurance (percentage may vary for certain covered services)	50%	50%	50%	40%	40%	40%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office (in person or online) visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$0 copay per visit for first 3 visits, then deductible, then $50 copay	$0 copay per visit for first 3 visits, then deductible, then $50 copay	$0 copay per visit for first 3 visits, then deductible, then $50 copay	$0 copay	$0 copay	$0 copay
Virtual visit from our online provider: LiveHealth Online	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Medical chat and virtual visit for primary care from our online provider: K Health	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Office and online visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	$80 copay	$80 copay	$80 copay
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance
Urgent care (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	$80 copay	$80 copay	$80 copay
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance
Hospital: inpatient admission (includes maternity, mental health/substance use)	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health/substance use)	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tiers 1,2,3,4: No deductible	Tiers 1,2,3,4: No deductible	Tiers 1,2,3,4: No deductible	Tiers 1,2,3,4: No deductible	Tiers 1,2,3,4: No deductible	Tiers 1,2,3,4: No deductible
Retail pharmacy tier 1: Level 1 / Level 2	$30 copay	$30 copay	$30 copay	$20 copay	$20 copay	$20 copay
Retail pharmacy tier 2: Level 1 / Level 2	$200 copay	$200 copay	$200 copay	$125 copay	$125 copay	$125 copay
Retail pharmacy tier 3: Level 1 / Level 2	$350 copay	$350 copay	$350 copay	$300 copay	$300 copay	$300 copay
Retail pharmacy tier 4: Level 1 / Level 2	$700 copay	$700 copay	$700 copay	$650 copay	$650 copay	$650 copay
Physical and occupational therapy[2] (limits apply)	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance
Speech therapy[2] (limits apply)	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance

Please see Medical plans footnotes on page 9.

Medical plans 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, and mammograms, as recommended by the United States Preventive Services Task Force.

2 **Physical, occupational, or speech outpatient therapy** is 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 6th birthday, both of these benefits are provided as required by applicable law.

Terms you need to know

Coinsurance: Your percentage of healthcare costs after your deductible has been paid.

Copay: The set dollar amount you pay for covered services, such as doctor visits.

Deductible: The set dollar amount you are responsible for before your plan pays for healthcare services. Deductibles apply to the calendar year (January 1 - December 31), even if your coverage start date is after January 1.

Drug tiers: Drugs on a drug list/formulary are typically arranged in tiers. Your drug's cost depends on its tier.

In-network coverage: In-network coverage means visiting a participating doctor, hospital, or another provider who accepts a negotiated amount from your health insurance plan.

Network: A network is made up of doctors, hospitals, pharmacies, and other providers offering medical care at negotiated rates to health plan members.

Out-of-network coverage: Out-of-network coverage means visiting a doctor, hospital, or another provider who does not accept your health insurance plan. You will be responsible for covering care costs minus emergent or preapproved services.

Out-of-pocket maximum: This is the maximum amount you will pay out-of-pocket for covered health services. After reaching your yearly maximum, your health plan covers the rest.

Plan name: The plan name and contract code are found on the first row of the medical plan charts, in parentheses after the plan name: "(WXYZ)."

Premium: This is the amount of money you pay monthly to your insurance company to keep your health plan active. You cannot apply what you pay for your premium toward your deductible.

Preventive care: These are medical services, like checkups, screenings, and vaccines, that can help you avoid illness and catch problems early. Preventive care is covered at $0 when you visit a provider in your plan's network.

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 do not 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. You or your spouse may qualify if one of you experiences a decrease in household income that results in eligibility for financial assistance through the government in paying your premium, provided you or your spouse had Minimum Essential Coverage for one or more days in the 60 days prior to the date of the financial change.

Effective date of coverage

The earliest effective date for the annual open enrollment period is the first day of the following benefit period. 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 (UR) is a program that is part of your health plan. It lets us make sure you are 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.

Important legal information

- 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 is 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.

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 is how requesting precertification can help you:

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 is 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 are 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.

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

Important legal information

- 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 and not covered under your Certificate. 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.

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:

- Acupuncture is covered for 6 visits
- Ambulance services (non-emergency transportation) – $50,000 per occurrence if an out-of-network provider is used. Out-of-network ambulance for non-emergency services is covered only if precertified by us.
- Applied behavior analysis for autism - includes services through age 18
- Hearing aids – 1 pair every 5 years for members under age 18
- Home health care – 28 hours per week
- Rehabilitative care (outpatient only) – An equal number of therapy visits are available for habilitative care (outpatient only)
  - Chiropractic care – 20 visits per member per year
  - Occupational therapy – 20 visits per member per year
  - Physical therapy – 20 visits per member per year
  - Speech therapy – 20 visits per member per year
- Skilled nursing facility – 100 days per year

Exclusions

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

- 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

Important legal information

- 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
- Fraud, waste, abuse, and other inappropriate billing. Services from a out-of-network provider that are determined to be not payable as a result of fraud, waste, abuse or inappropriate billing activities. This includes a out-of-network provider's failure to submit medical records required to determine the appropriateness of a claim
- 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 are not 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 is important we treat you fairly

That is why we follow federal civil rights laws in our health programs and activities. We do not 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 is not 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.

Find help in your language

If you're curious to know what all this says, here is 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 አገልግለቶች ቁጥርን (1-855-383-7249) **በመደወል ያለምንም ክፍያ ማግኘት ይችላሉ።** (TTY/TDD: 711)

Arabic

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

Bassa

Ɔ jŭ ké m̀ dyi gbo-kpá-kpá mɔ́ ɓɛ́ m̀ ké céè-dɛ̀ nìà kɛ múin wɔ́ ɖé bãà-wɛ̃̄n wùɖù ɖò mú nǐ, m̀ ɓɛ̃́n ɔ zɔ̀ɔ̀ dyìin ɖé Mɛ́ɓà jè gbo-gmɔ̀ Kpòɛ̀ nɔ̀ɓà nìà kɛ <1-855-383-7249> ɖá ɖá mú. M̀ se wǐɖǐ kàkò ɖò pɛ̃́n 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 اعضاء 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 dọkụmentị a n’asụsụ dị iche, ị nwere ike ịrịọ ya na akwụghị ụgwọ ọ bụla ọzọ site na ịkpọ nọmba Ọrụ Onye Otu (1-855-383-7249). (TTY/TDD: 711)

Japanese

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

Korean

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

Find help in your language

Nepali

यदि तपाईंलाई यो कागजात कुनै अर्को भाषामा बुझ्न सहायता चाहिएमा, तपाईंले सदस्य सेवा नम्बर (1-855-383-7249) मा कल गरेर कुनै अतिरिक्त खरच बिना यसको लागि अनुरोध गरन 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)

Vietnamese

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

Yoruba

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

Open enrollment period runs

November 1, 2022 - January 15, 2023

Reimagining what's possible for every moment of care

We know finding a plan that works for you and your loved ones is a big decision. With Anthem you're never alone for the important choices.

Get started today

- Call us at **888-811-2101**, 6:30 a.m. to 6:00 p.m. MT or contact your broker.
- Visit **anthem.com**, select **Individual and Family**, and apply online.
- For off-Marketplace plans, review the **application** included with this brochure.

Let us connect you to the right individual coverage.

Qualifying life events

If you experience a major life event, you may need to make plan changes outside the sign-up period. To see if your life event qualifies for a plan change, call us at **888-811-2101** or contact your broker.

You can buy health plans once a year during open enrollment.
For 2023, this period runs from **November 1, 2022 - January 15, 2023. Dates may change and vary by state.**

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

Printed kits available from your broker upon request.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare professional in your plan's network. If you receive care from a doctor or healthcare professional not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.
Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of Anthem Blue Cross and Blue Shield health plans. The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.
Other virtual care services offered through an arrangement with LiveHealth Online. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem Blue Cross and Blue Shield.
Copies of Colorado network access plans are available on request from Member Services or can be obtained by going to anthem.com/co/networkaccess.

A02055COMENABS 7/22

Colorado

BENEFIT CHARTS

Anthem

Pediatric dental and vision

Benefits included with your medical plan

2023 Individual and Family Plans

Plans on and off the Marketplace

Open enrollment period runs November 1, 2022 - January 15, 2023

A0035OCOMENABS_2023 8/22

Pediatric Dental Benefits
included for plans on and off the Marketplace

Pediatric dental benefits are included with all of our medical plans for individuals 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

Cost shares show what the member pays	Medical plans[1] Members age 18 and younger In-network
Dental network	Dental Prime
Deductible	Dental services subject to the medical deductible
Annual maximum (per person)	None
Annual out-of-pocket maximum	Combined with medical
Diagnostic and preventive	No waiting period
Cleaning, exams, x-rays	0% coinsurance
Basic services	No waiting period
Fillings	50% coinsurance
Complex and major services	No waiting period
Endodontic	50% coinsurance
Periodontic	Not covered
Oral surgery	50% coinsurance
Major restorative	50% coinsurance
Medically necessary orthodontia[2]	50% coinsurance
Cosmetic orthodontia	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 trying to bite down.

Pediatric Vision Benefits
included for plans on and off the Marketplace

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, eyeglass 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.

Cost shares show what the member pays	CO - P2		CO - CAT - P6	
	Members age 18 and younger		Members age 18 and younger	
	Benefit Frequency	Cost share In-network	Benefit Frequency	Cost share In-network
Eye exam	Once every benefit period	$0 copay	Once every benefit period	$0 copay
Lenses				
Single, bifocal, and trifocal	Once every benefit period	$0 copay	Once every benefit period	$0 copay
Standard progressive	Once every benefit period	$0 copay	Once every benefit period	$0 copay
Frames	Once every benefit period	Anthem formulary[1]	Once every benefit period	Anthem formulary[1]
Contact lenses				
Non-elective[2]	N/A	Anthem formulary[1]	N/A	Anthem formulary[1]
Elective/disposable[2]	N/A	Anthem formulary[1]	N/A	Anthem formulary[1]
Low vision services				
Low vision optical/ non-optical or supplemental aids	N/A	Not covered (benefits are only available when received from Blue View Vision providers)	N/A	Not covered (benefits are only available when received from Blue View Vision providers)

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

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

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Colorado
PRODUCT GUIDE

Anthem

Connecting you to the right coverage

Dental and vision

2023 Individual and Family Plans

Plans off the Marketplace

Anthem Essential Choice PPO and Anthem Dental Family PPO plans and Blue View Vision plans

For plans effective January 1, 2023

1040245COMENABS_OFF_2023 DAT BV 03/22

Helping you feel covered, protected, and confident

Our plans for individuals and families are designed to help protect both your health and your finances. With a range of options suited to different budgets, we can connect you to the coverage that's right for you.

Why connected care matters

Regular dental checkups are about more than keeping your mouth healthy. They can help dentists identify health conditions like heart disease and diabetes.[1]

Likewise, eye exams can help eye doctors find early signs of diabetes, high blood pressure, high cholesterol, and other serious health issues beyond your vision.[2]

That's why we want to make it easier for you to access the dental and vision care you need. ▷

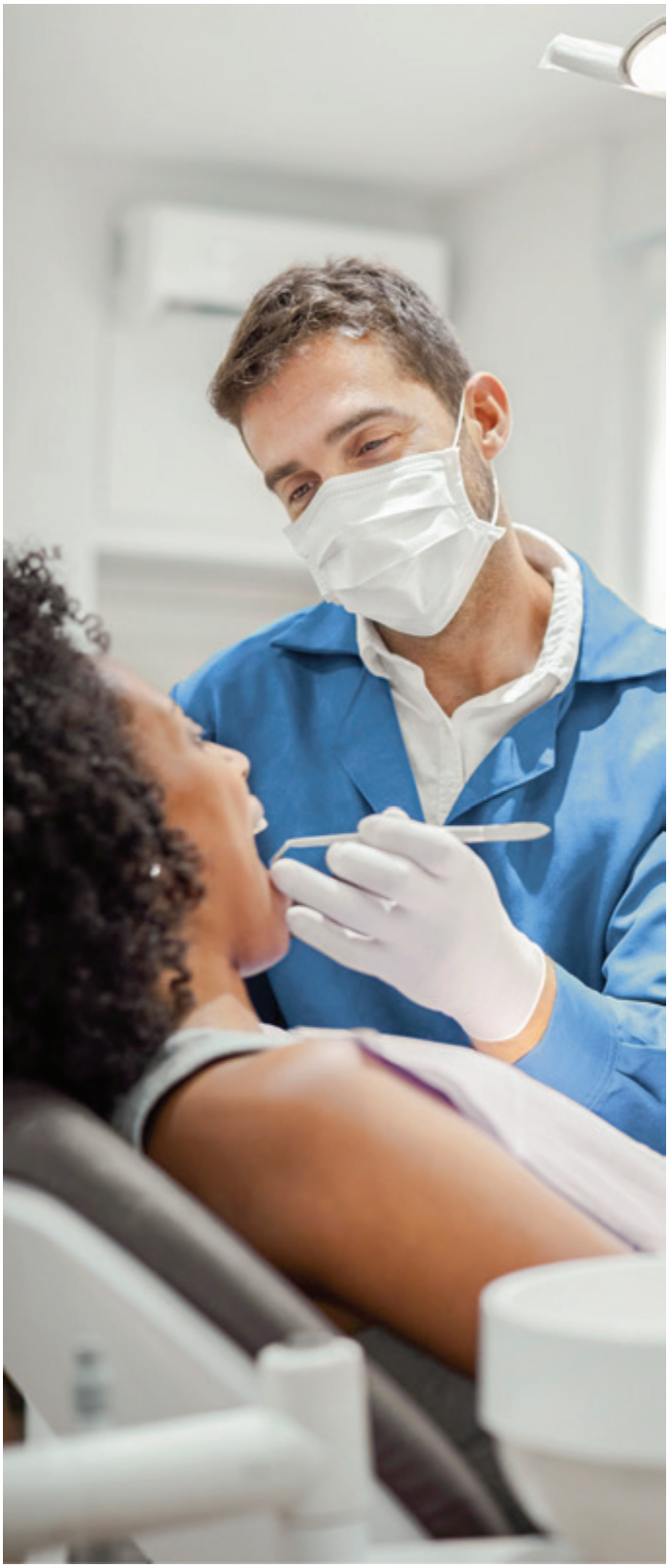
Purchasing a plan

To help protect your overall health, you can buy dental and vision plans on their own all year round without having to wait until the next open enrollment period.

[1] Centers for Disease Control and Prevention: ***Oral Health Conditions*** (accessed April 2022): **cdc.gov/oralhealth/conditions/index.html.**

2 Your Sight Matters: 7 Health Problems Eye Exams Can Detect (accessed April 2022): yoursightmatters.com.

Dental plan benefits



When you choose Anthem, you can use one of the largest dental networks in the country. That means you're likely to find a dentist close to your home or work, or even be able to see a dentist you already know and trust.

Plus, you'll receive 100% coverage for preventive care, like regular dental cleanings, exams, and X-rays, when you go to a dentist in your plan. There are no waiting periods with preventive care, so those benefits can be used right away. Anthem has strong network discounts — our members save more by visiting one of our network dentists with our 38% average national network discount.*

Our Essential Choice PPO dental plans have higher annual benefit maximums. These plans allow you to carry over part of your unused benefits to the next year, with the potential to double your annual maximum benefit amount over time. Essential Choice PPO dental plans also feature shorter waiting periods than traditional plans for basic and major services, and our Incentive plan does not have any waiting periods.

Important health plan terms to know

Monthly premiums: your payments for plan benefits

Levels of coverage: the types of benefits covered

Deductibles: the amount of expenses you have to pay out of pocket every calendar year before your plan begins to pay for benefits

Benefit waiting period: the period of time you have to wait until your plan starts covering benefits

Copays: a fee you pay for each provider visit

Coinsurance: the amount you pay for healthcare services; usually a certain percentage of the cost after your deductible has been paid

* Anthem Network Discount report, 2022.

Dental plan benefits

We offer a variety of individual and family plan options, including:

Anthem Essential Choice PPO dental plans

You can choose among these five plan options, which offer different monthly premiums, annual benefit maximums, and levels of coverage.*

- **Basic** — covers preventive care and basic services, including nonsurgical gum treatments and tooth removal
- **Select** — covers major services, like root canals, oral surgery, crowns, bridges, and dentures; also covers cosmetic teeth whitening
- **Classic** — covers all of the above, with lower out-of-pocket costs for basic services; has a higher annual maximum benefit ($1,500) than the Bronze and Silver plans
- **Premier** — covers all of the above, plus dental implants and orthodontics for children; has a higher annual maximum benefit ($2,000) than the Bronze, Silver, and Gold plans
- **Incentive** — innovative plan with no waiting periods for any services; offers rewards for receiving preventive care by increasing the benefits for basic and major services the next year; at $2,500, has the highest annual maximum benefit of any plan

Anthem Dental Family PPO plans

Each one of our Dental Family plans covers the pediatric dental essential health benefits for children up to age 19. You can choose from these three benefit levels for adults:

- **Anthem Dental Family Value** — covers preventive care and basic services, like fillings and nonsurgical tooth removal
- **Anthem Dental Family** — covers preventive care, basic services, and more complex procedures, like root canals, oral surgery, crowns, and dentures
- **Anthem Dental Family Enhanced** — covers all of the above, with lower out-of-pocket costs for both adults and children; also covers cosmetic orthodontics for children

To compare dental plan benefits, **see our detailed charts**.

* All five plans cover tooth-colored fillings on back teeth.

Dental plan resources

Lower your out-of-pocket costs

You will save the most money if you see a dentist in your plan's network. Those dentists have agreed to accept rates negotiated by your plan, so you can save money on the services you need, when you need them — including during any waiting periods and after you reach your annual maximum benefit.

Find a dentist

To find dental care near you, go to anthem.com/find-care.

Helping you stay connected

Through technology and innovation, we are working hard to improve health outcomes, control costs, and enhance your overall care experience.

All our plans come with online tools to make it easier for you to find care, get your benefit information, and learn about different health topics. Once you become a member, you can simply log in to **anthem.com** to use:

Ask a Hygienist
Email questions to licensed dental professionals and receive quick, private, and personalized advice at no extra cost.

Dental Cost Estimator
Estimate your costs for dental procedures and services in your ZIP code before receiving care.

Dental Health Assessment
Answer a few questions to get feedback about your dental health status.

TeleDentists®
Get virtual dental care, including emergency exams and medication prescriptions, as needed.

Dental care when you're away from home

If you travel outside the U.S., you have access to emergency dental services through the International Emergency Dental Program, which comes with all our plans.*

With one call, you can get help finding an English-speaking dentist when you have an urgent dental care need. You can even request translation services when you call the dentist's office. Services received through this program will not count toward your yearly limit, if your plan has one.

* 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.

Connected care and discounts

The Sydney Health app

Our app brings valuable health plan information together in one place — to put you in control and make staying on top of your care more convenient.

With Sydney℠ Health, you can:

- View digital ID cards and plan, prescription, or claims information.
- Use interactive chat for health questions.
- Find nearby care.
- Compare costs for healthcare services.
- Take advantage of the Symptom Assessment tool.

Once you enroll in one of our plans, Sydney Health is available for free download on the App Store® or Google Play™.

You will need a smartphone, tablet, or other personal device to get started.

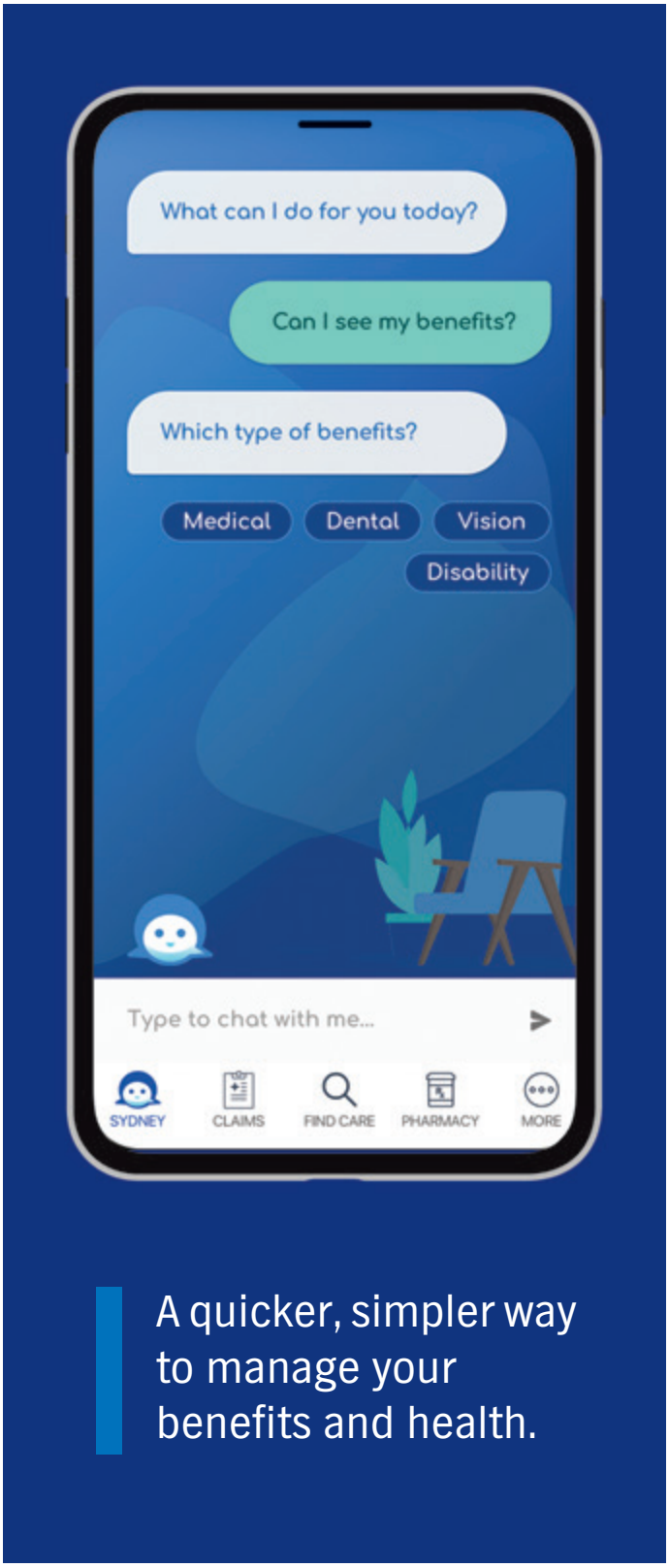
Discounts that make a difference

Through SpecialOffers@Anthem℠, you can also receive discounts on at-home teeth-straightening aligners and other health and wellness products and services that may not be covered under your plan.

A focus on whole-person health

The Anthem Whole Health Connection® program links your Anthem plans together — to give your doctors a more complete picture of your health.*

This makes managing all aspects of your care simpler, smarter, and more cost-effective. It also allows for truly meaningful connections, improved outcomes, and stronger relationships between you and your care team.



* Anthem Whole Health Connection is included at no extra charge for employees with Anthem health and wellness coverage and one or more of the following plans from us: pharmacy, dental, vision, disability, and supplemental health.

Blue View Vision plan benefits

With Blue View Vision, choose from more than 40,000 eye doctors and other eye care providers at over 30,000 locations.[1] You can go to an independent eye doctor or popular retailers, such as LensCrafters®, Target Optical®, and most Pearle Vision® locations. Our network is one of the largest in the country, so you'll be able to receive your eye care, glasses, and other accessories just about anywhere. Plus, you'll have 24/7 access to online stores, including Glasses.com, ContactsDirect or 1-800 CONTACTS®.

Plan features

Our plans are designed to give you options. They all have:

- Coverage for yearly eye exams.
- Add-ons, including factory scratch coating on eyeglass lenses, at no extra cost.
- Discounts for other add-ons, including Transitions® lenses, premium progressive lenses, and premium antireflective coatings.
- Value-added savings,[2] including 15% to 40% off most extra pairs of glasses, contact lenses, lens treatments, specialized lenses, and various accessories — even after you've used all of your covered benefits.
- Discounts through SpecialOffers@Anthem℠, for LASIK and other products and services that promote health and well-being.

Bundled plan

This plan is only available with a medical and/or dental plan. It cannot be purchased as a stand-alone plan.

Stand-alone plans

If you'd like to buy vision coverage separate from medical and dental, we offer the following plan options:

Individual and family plans

You can choose from these three plans:

- Value
- Plus
- Enhanced

Our comprehensive plans include options for adding the latest lens enhancements for members over age 19.

You can choose from these five plans:

- Progressive Select
- Progressive Preferred
- Basic
- Premier
- Ultra

1 NetMinder data, May 2020.

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

Pediatric vision benefits

Our Bundled, Value, Plus, and Enhanced plans cover exams, lenses, and frames for children. These add-ons are also available at no extra charge:

- Transitions lenses, to protect eyes from ultraviolet rays
- Polycarbonate lenses, with scratch coating to protect lenses

Savings example

When you have a Blue View Vision plan from Anthem, it can often pay for itself.

	Retail	Member copay	Member cost	Member saves
Exam	$80	$20	$20	**$60**
Frame	$130	None	$0	**$130**
Bifocal lenses	$80	$20	$20	**$60**
Scratch coating	$22	None	$0	**$22**
Progressive premium tier 1	$140	None	$85	**$55**
Polycarbonate lenses	$55	None	$40	**$15**
Antireflective premium tier 2	$100	None	$68	**$32**
Transition lenses	$110	None	$75	**$35**
Total	$717			**$409**

To compare vision plan benefits, **see our detailed charts.**

For plans effective **January 1, 2023**

Your trusted partner in health

We're here to help you make the best decision for you, your family, and your budget — with guidance, support, and resources every step of the way.

You can sign up today for our dental and vision plans

Apply online: To shop and compare plans, go to anthem.com and select Individual & Family.

Apply on paper: You will need to fill out and sign the application. Then, give it to your representative or mail it to us at the address on the form.

Let us connect you to the right individual coverage.

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Colorado
BENEFIT CHARTS

Anthem

Dental and vision

Benefit charts

2023 Individual and Family Plans

Plans off the Marketplace

Anthem Essential Choice PPO Anthem Dental Family PPO plans, and Blue View Vision plans

For plans effective January 1, 2023

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Anthem Essential Choice PPO plans

Cost shares show what the member pays	Essential Choice Basic	Essential Choice Select	Essential Choice Classic	Essential Choice Premier	Essential Choice Incentive
	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
Diagnostic and preventive	**No waiting period**	**No waiting period**	**No waiting period**	**No waiting period**	**No waiting period**
Cleaning, exams, x-rays	0% / 20% coinsurance	0% / 0% coinsurance	0% / 20% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance
Basic services	**3-month waiting period**	**3-month waiting period**	**3-month waiting period**	**3-month waiting period**	**No waiting period**
Fillings	50% / 50% coinsurance	50% / 50% coinsurance	20% / 40% coinsurance	20% / 20% coinsurance	40% / 40% coinsurance *Rewards yearly preventive care by lowering the coinsurance by 10% the following year, up to 20% coinsurance on Basic and 50% on Major.*
Brush biopsy	Covered	Covered	Covered	Covered	Covered
Complex and major services (includes teeth whitening)	**6-month waiting period**	**6-month waiting period**	**6-month waiting period**	**6-month waiting period**	**No waiting period**
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	Not covered	50% / 50% coinsurance	50% / 50% coinsurance	50% / 50% coinsurance	70% / 70% coinsurance *Rewards yearly preventive care by lowering the coinsurance by 10% the following year, up to 20% coinsurance on Basic and 50% on Major.*
Prosthetics (crowns, dentures, bridges)	Not covered	50% / 50% coinsurance	50% / 50% coinsurance	50% / 50% coinsurance	70% / 70% coinsurance *Rewards yearly preventive care by lowering the coinsurance by 10% the following year, up to 20% coinsurance on Basic and 50% on Major.*
Orthodontia (children covered up to age 19)	Not covered	Not covered	Not covered	$150 deductible, then 50% coinsurance *$1,000 lifetime maximum for orthodontia ($500 per year), after 12 month waiting period.*	$150 deductible, then 50% coinsurance *$1,000 lifetime maximum for orthodontia ($500 per year).*
Dental network	**Dental Prime**	**Dental Prime**	**Dental Prime**	**Dental Prime**	**Dental Prime**
Deductible (per person, all services)	$50 per person, $150 per family *Deductible is waived for diagnostic and preventive services received in our network.*	$50 per person, $150 per family *Deductible is waived for diagnostic and preventive services received in our network.*	$50 per person, $150 per family *Deductible is waived for diagnostic and preventive services received in our network.*	$50 per person, $150 per family *Deductible is waived for diagnostic and preventive services received in our network.*	$50 per person, $150 per family *Deductible is waived for diagnostic and preventive services received in our network.*
Annual maximum (per person)	**$1,000**	**$1,000**	**$1,500**	**$2,000**	**$2,500**
Annual out-of-pocket limit	**None**	**None**	**None**	**None**	**None**
International emergency dental program	Included	Included	Included	Included	Included

Anthem Dental Family PPO plans

Cost shares show what the member pays	Dental Family Value		Dental Family		Dental Fa
	Members age 18 and younger	Adults age 19+	Members age 18 and younger	Adults age 19+	Members age 18 and younger
	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
Diagnostic and preventive	**No waiting period**	**No waiting period**	**No waiting period**	**No waiting period**	**No waiting period**
Cleaning, exams, x-rays	0% / 30% coinsurance	0% / 50% coinsurance	0% / 30% coinsurance	0% / 50% coinsurance	0% / 20% coinsurance
Basic services	**No waiting period**	**6-month waiting period**	**No waiting period**	**6-month waiting period**	**No waiting period**
Fillings	40% / 50% coinsurance	50% / 75% coinsurance	40% / 50% coinsurance	50% / 75% coinsurance	20% / 40% coinsurance
Brush biopsy	Not covered	Covered	Not covered	Covered	Not covered
Complex and major services	**No waiting period**	**Not covered**	**No waiting period**	**12-month waiting period**	**No waiting period** ***Except 12-month waiting period for cosmetic orthodontia.***
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	50% / 50% coinsurance *Coverage for pediatric children does not cover periodontic or prosthetic services.*	Not covered	50% / 50% coinsurance *Coverage for pediatric children does not cover periodontic or prosthetic services.*	70% / 85% coinsurance	20% / 50% coinsurance
Prosthetics (crowns, dentures, bridges)	50% / 50% coinsurance *Coverage for pediatric children does not cover periodontic or prosthetic services.*	Not covered	50% / 50% coinsurance *Coverage for pediatric children does not cover periodontic or prosthetic services.*	70% / 85% coinsurance	50% / 50% coinsurance *Coverage for pediatric children does not cover periodontic or prosthetic services.*
Medically necessary orthodontia	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	Not covered	50% / 50% coinsurance
Cosmetic orthodontia	Not covered	Not covered	Not covered	Not covered	50% / 50% coinsurance *$1,000 lifetime maximum for cosmetic orthodontia.*
Dental network	**Dental Prime**	**Dental Prime**	**Dental Prime**	**Dental Prime**	**Dental Prime**
Deductible (per person, all services)	$50	$50	$50	$50	$25
Annual maximum (per person)	**None**	**$750**	**None**	**$750**	**None**
Annual out-of-pocket limit	**$375 / None** ***Per child, up to $750 per family.***	**None**	**$375 / None** ***Per child, up to $750 per family.***	**None**	**$375 / None** ***Per child, up to $750 per family.***
International emergency dental program	Included	Included	Included	Included	Included

Blue View Vision plans

The Blue View Vision Bundled plan can only be purchased with a medical and/or dental plan. All other Blue View Vision plans listed on these pages can be purchased with or without a medical and/or dental plan.

	Blue View Vision Bundled		Blue View Vision Enhanced		Blue View Vision Plus		Blue View Vision Value	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Eye exam (with dilation as needed)	$20 copay	$30 Reimbursement	$10 copay	$30 Reimbursement	$10 copay	$30 Reimbursement	$20 copay	$30 Reimbursement
Frequency	Once every 12 months	Once every 12 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses								
Single vision	$20 copay	$25 Reimbursement	$10 copay	$25 Reimbursement	$20 copay	$25 Reimbursement	$20 copay	$25 Reimbursement
Bifocal	$20 copay	$40 Reimbursement	$10 copay	$40 Reimbursement	$20 copay	$40 Reimbursement	$20 copay	$40 Reimbursement
Trifocal	$20 copay	$55 Reimbursement	$10 copay	$55 Reimbursement	$20 copay	$55 Reimbursement	$20 copay	$55 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Lens add-ons								
Factory Scratch	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered
Tint	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered
Standard anti-reflective coating	$45 copay	Not covered	$45 copay	Not covered	$45 copay	Not covered	$45 copay	Not covered
Standard progressive lens *The copay is in addition to bifocal copay.*	$65 copay	$40 Reimbursement	$65 copay	$40 Reimbursement	$65 copay	$40 Reimbursement	$65 copay	$40 Reimbursement
Polycarbonate								
Members under age 19	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered
Members age 19 and over	$40 copay	Not covered	$40 copay	Not covered	$40 copay	Not covered	$40 copay	Not covered
Transitions								
Members under age 19	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered
Members age 19 and over	$75 copay	Not covered	$75 copay	Not covered	$75 copay	Not covered	$75 copay	Not covered
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Frames	$130 allowance	$45 Reimbursement	$150 allowance	$45 Reimbursement	$130 allowance	$45 Reimbursement	$130 allowance	$45 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every other calendar year	Once every other calendar year	Once every other calendar year	Once every other calendar year
Contact lenses Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.								
Elective (conventional and disposable)	$80 allowance	$60 Reimbursement	$150 allowance	$60 Reimbursement	$130 allowance	$60 Reimbursement	$80 allowance	$60 Reimbursement
Nonelective	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year

Blue View Vision plans

The Blue View Vision Bundled plan can only be purchased with a medical and/or dental plan. All other Blue View Vision plans listed on these pages can be purchased with or without a medical and/or dental plan.

	Blue View Progressive Preferred		Blue View Progressive Select		Blue View Vision Basic		Blue View Vision Premier	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Eye exam (with dilation as needed)	$10 copay	$30 Reimbursement	$10 copay	$30 Reimbursement	$20 copay	$30 Reimbursement	$10 copay	$30 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses								
Single vision	$10 copay	$25 Reimbursement	$20 copay	$25 Reimbursement	$20 copay	$25 Reimbursement	$20 copay	$25 Reimbursement
Bifocal	$10 copay	$40 Reimbursement	$20 copay	$40 Reimbursement	$20 copay	$40 Reimbursement	$20 copay	$40 Reimbursement
Trifocal	$10 copay	$55 Reimbursement	$20 copay	$55 Reimbursement	$20 copay	$55 Reimbursement	$20 copay	$55 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Lens add-ons								
Factory Scratch	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered
Tint	$5 copay	Not covered	$5 copay	Not covered	$15 copay	Not covered	$5 copay	Not covered
Standard anti-reflective coating	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered
Standard progressive lens *The copay is in addition to bifocal copay.*	$30 copay	$40 Reimbursement	$30 copay	$40 Reimbursement	$65 copay	$40 Reimbursement	$65 copay	$40 Reimbursement
Polycarbonate								
Members under age 19	$40 copay	Not covered	$40 copay	Not covered	$40 copay	Not covered	$40 copay	Not covered
Members age 19 and over	$10 copay	Not covered	$10 copay	Not covered	$10 copay	Not covered	$10 copay	Not covered
Transitions								
Members under age 19	$65 copay	Not covered	$65 copay	Not covered	$65 copay	Not covered	$65 copay	Not covered
Members age 19 and over	$20 copay	Not covered	$20 copay	Not covered	$20 copay	Not covered	$20 copay	Not covered
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Frames	$150 allowance	$45 Reimbursement	$130 allowance	$45 Reimbursement	$150 allowance	$45 Reimbursement	$180 allowance	$45 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Contact lenses Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.								
Elective (conventional and disposable)	$150 allowance	$60 Reimbursement	$130 allowance	$60 Reimbursement	$150 allowance	$60 Reimbursement	$180 allowance	$60 Reimbursement
Nonelective	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year

Blue View Vision plans

The Blue View Vision Bundled plan can only be purchased with a medical and/or dental plan. All other Blue View Vision plans listed on these pages can be purchased with or without a medical and/or dental plan.

	Blue View Vision Ultra	
	In-network	**Out-of-network**
Eye exam (with dilation as needed)	$10 copay	$30 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses		
Single vision	$10 copay	$25 Reimbursement
Bifocal	$10 copay	$40 Reimbursement
Trifocal	$10 copay	$55 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Lens add-ons		
Factory Scratch	$0 copay	Not covered
Tint	$5 copay	Not covered
Standard anti-reflective coating	$15 copay	Not covered
Standard progressive lens *The copay is in addition to bifocal copay.*	$65 copay	$40 Reimbursement
Polycarbonate		
Members under age 19	$40 copay	Not covered
Members age 19 and over	$10 copay	Not covered
Transitions		
Members under age 19	$65 copay	Not covered
Members age 19 and over	$20 copay	Not covered
Frequency	Once every calendar year	Once every calendar year
Frames	$200 allowance	$45 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Contact lenses Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.		
Elective (conventional and disposable)	$200 allowance	$60 Reimbursement
Nonelective	$0 copay	$210 Reimbursement
Frequency	Once every calendar year	Once every calendar year

Limits and Exclusions

Exclusions - Blue View Vision

- Services not listed in the "Your Vision Benefits" section of the Booklet.
- Sunglasses. Sunglass lenses or accompanying frames.
- Any amounts in excess of the maximum benefits stated in the Booklet.
- Premium contact lenses fittings.
- Cosmetic lens options not specifically listed in the "What is Covered" section of the Booklet.
- Any non-prescription lenses, eyeglasses or contacts, or plano lenses or lenses that have no refractive power.
- Any diagnostic testing or medical or surgical treatment of the eyes, including any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. We also will not cover any contact lenses or eyeglasses required as a result of this surgery.
- Any lost or broken lenses or frames, unless you have reached a new benefit period.
- Services received before your effective date or after your coverage ends.
- Services for which you are not legally obligated to pay, for which you are not charged, or for which no charge is made in the absence of insurance coverage.
  Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation law or similar law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to any workers' compensation law or similar law, we will provide the benefits of this plan for such condition, subject to our right to a lien or other recovery applicable law.
  Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- Treatment or services rendered by non-licensed providers and treatment or services for which the provider of services is not required to be licensed.
- Services of relatives.
- Orthoptics or vision training and any associated supplemental testing.
- Missed or cancelled appointments.
- Services or supplies combined with any other offer, coupon or in-store advertisement.

WAYS AN ANTHEM HSA CAN WORK FOR YOU

An Anthem Health Savings Account (HSA) can simplify saving money for healthcare – to use when you need it most.

An Anthem HSA account can help you:

1. Pay for healthcare expenses, like prescription drugs.
2. Have more control over how you spend your healthcare dollars.
3. Make educated care decisions using our tools and resources.
4. Save money on taxes by claiming your HSA contributions as tax deductions, earning interest on your money, and rolling over the year-end balance.

REAL-TIME ALERTS FOR YOUR ANTHEM HSA

You can sign up to receive email or text message alerts at anthem.com.

These will notify you about changes in your account balance, as well as new deposits, statements, and other updates.

When you choose an Anthem HSA, it's all in one:

Debit card. You receive one debit card to pay for out-of-pocket healthcare costs.

Website. You can find all your benefit and spending account information on one website to:

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

App. You can access the Sydney Health℠ app from home or on the go. With one app, you can:

- See 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.

You can download the Sydney Health app from the App Store® or Google Play™.

Customer Service team. You have one phone number for all your customer service needs. You can feel confident, knowing you have a team of service experts waiting to help you

Anthem

USING YOUR ANTHEM HSA

Open your HSA account

To open an HSA, you must have an HSA-compatible, high-deductible health plan.

Once you decide to open your HSA, our banking partner will confirm your identity, as required by law, and notify you if additional information is needed.[1]

Keep in mind, the information you provide at enrollment is used to open your account and confirm your identity. It is important that you enroll using your legal name to avoid delays in opening your account.

Receive your welcome letter and debit card

Once your account is open:

- You can log on to **anthem.com** to see your account information at any time.
- You can learn more about your health plan, benefits, and HSA at **anthem.com**.
- You will receive a welcome letter and debit card issued to you and your spouse or domestic partner.[2]

Transfer HSA funds

If you already have an HSA, you can transfer your funds to your new Anthem HSA for:

- **A simpler experience.** With your funds in one place, you will have one login, one statement, one mobile app, one support team, and one debit card.
- **More savings by reducing fees.** By consolidating funds and closing your other account, you eliminate account administration fees from your prior HSA custodian.[3]
- **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.
- **Increased investment opportunity.** By combining your accounts, you have the maximum opportunity to grow your savings for the future.

We are here to support you. Once your account is open, please visit **anthem.com** or the Sydney Health app. You can also call Member Services at the number on the back of your ID card for details. We want you to feel confident knowing you're protected, informed, and supported.

This is what the IRS requires if you want to open an HSA:

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

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

1 Under the Patriot Act, all financial institutions are required to confirm the identity of anyone opening a new account through the Consumer Identification Program (CIP).

2 A debit card will automatically be issued to you and your spouse or domestic partner. If you need debit cards for other dependents, you can order them online at anthem.com or call Member Services at the number on your ID card.

3 Please note that your prior HSA custodian may charge a fee to transfer and close your account.

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COLORADO UNIFORM **INDIVIDUAL** APPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's application for coverage. Please contact your carrier with questions regarding this form.

Federal financial assistance may be available for coverage purchased through Connect for Health Colorado. If purchasing coverage through Connect for Health Colorado, you will need to provide additional information for determination of eligibility for federal financial assistance. Further information may be found at www.connectforhealthco.com.

COVERAGE INFORMATION

Application Type: (check all that apply)	☐ New Coverage ☐ Change/Modification to Existing Coverage ☐ Open Enrollment ☐ Special Enrollment*				
Is the applicant purchasing this plan using a reimbursement arrangement (if applicable):	☐ Yes ☐ No	If so, what type:	☐ HRA	☐ ICHRA	☐ QSEHRA
Special Enrollment Period Qualifying event: ☐ Loss of Coverage ☐ Birth/Adoption/Placement for Adoption ☐ Marriage ☐ Other: _____ Date of Event: _____					
Requested Effective Date:	_____/_____/_____ (MM/DD/YYYY)				

*Proof of eligibility for special enrollment will be required − information available on the DOI website at: https://www.colorado.gov/pacific/dora/division-insurance

PRIMARY APPLICANT/INSURED INFORMATION

Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.

First Name:		Middle Initial:		Last Name:	
SSN/TIN/ALT ID #: (Optional)		Date of Birth:	/ /	Current Age:	Gender: ☐ M ☐ F ☐ X

SSN is only necessary to determine eligibility for federal Advance Premium Tax Credit and Cost Sharing Reductions. Not filling out this field shall not be a reason to deny an application for coverage.

Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different, can be P.O. Box):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	

Are you (check one): ☐ Single ☐ Married ☐ Common Law ☐ Civil Union ☐ Legally Separated ☐ Divorced ☐ Under 21

Are you or is anyone in your family American Indian or Alaskan Native? ☐ Yes ☐ No
This question is being asked as American Indians and Alaskan Natives have an enhanced ability to enroll in health benefit plans

ADDITIONAL APPLICANTS

Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26 (older if medically disabled) are applying for coverage. If a dependent child is applying as an individual rather than as part of a family list the child as the primary applicant. If there is not enough space provided, please attach additional family information. Please sign and date the additional sheet. SSN is only necessary to determine eligibility for federal Advance Premium Tax Credit and Cost Sharing Reductions. Not filling out that field shall not be a reason to deny an application for coverage.

Name (First, MI, Last)	SSN/TIN/ALT ID #:	Gender	Relationship	Disability Y/N	Birth Date (MM/DD/YY)
		☐ M ☐ F ☐ X	SPOUSE/PARTNER	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	
		☐ M ☐ F ☐ X	☐ Child ☐ Dependent	☐ Yes ☐ No	

Do(es) the child(ren) named within the application live with you at the same physical address shown above? ☐ Yes ☐ No (if no, complete below)

Child(ren)´s Name:				Mailing Address (If different):	
City:		County:		State:	Zip:
Home Phone:		Alternate Phone:		Email:	

Name of the Legal Guardian or Parent responsible for carrying health insurance for the child:							
If the primary applicant is under the age of 21 and different from above, provide the name and mailing address of the legal guardian or custodial parent:							
Legal Guardian or Custodial Parent's Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used." Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No
	☐ Yes	☐ No

MEDICARE/MEDICAID INFORMATION

Is any applicant enrolled in Medicare?	☐ Yes	☐ No

Name of person covered by Medicare: _____

For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program?	☐ Yes	☐ No

Name of person covered by Medicaid or other governmental health program: _____. For this applicant, please be aware that obtaining individual health insurance may affect which coverage is primary and/or applicant's eligibility for APTC.

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? ☐ Yes ☐ No

(Dental Coverage in next Section)

Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type

If any applicant has current health coverage, will that applicant cancel current coverage if this application is accepted? ☐ Yes ☐ No

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only; O = Other, please explain: _____

CERTIFICATION OF DENTAL INSURANCE COVERAGE (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required to provide proof that you have obtained coverage before this policy will be approved

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved. (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)

I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I would like to receive all policy notices, premium notices, and other notices relating to this policy through the supplied email address above.
☐ Yes ☐ No

I understand I can change this designation at a later date by contacting my carrier directly, and understand it is my responsibility to notify my carrier of any changes to my email address.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	Date Signed:
Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:

AGENT/PRODUCER INFORMATION	
This section is to be completed by Agent or Producer.	
Agent/Agency of Record: (for commissions and correspondence)	Writing Agent/Producer:
Name (print):	Name (print):
Agent ID # (NPN):	Agent ID # (NPN):
Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐ Yes ☐ No As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature.	
Writing Agent Signature	Date

DISCLOSURES

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://www.dora.colorado.gov/insurance. For questions regarding coverage or enrollment please see your carrier.

This section may be used to provide additional information that was required in the sections above and did not fit in the space provided.

_____

_____

_____

_____

_____

Signature of Primary Applicant: _____ Date Signed: _____

Primary applicant name: _____

Welcome

Colorado Individual Application Supplement Form

NOTE: THIS APPLICATION IS ONLY TO BE USED IN CONJUNCTION WITH THE UNIFORM INDIVIDUAL APPLICATION.

Thanks for choosing us. We're glad you're here.

If you have any questions while filling out this form, give us a call at 1 (877) 212-1793. But if you've worked with an agent or broker, contact them first.

About this form

Use this form to apply for **new** medical, dental or vision coverage or to **change** existing coverage with Anthem Blue Cross and Blue Shield (Anthem).

You can apply or change coverage:

1. **During the annual Open Enrollment period**
   Your coverage will start based on when we receive your complete application. The earliest date coverage can start is January 1st.
   If we get your application:
   - Between the 1st and 15th day of the month, coverage starts the 1st day of the following month.
   - Between the 16th and last day of the month, coverage starts the 1st day of the second following month.
2. **When you have a Special Enrollment period due to a qualifying event**
   When you're done with this form, fill out **Appendix A: Special Enrollment,** which includes information about qualifying events and when coverage starts.
3. **For new dental and vision**
   - For new dental and vision coverage, you can apply any time of the year.
   - If you apply with medical coverage, your effective dates will match.
   - If you apply without medical coverage, your effective date will be based on when we receive your complete application. Coverage starts the 1st day of the month after the date we receive your complete application.

Tips for filling out this form

- Answer all questions. Please print clearly using blue or black ink only.
- Please submit all pages.
- You can also apply online at anthem.com.
- Refer to your Product Guide for plan and enrollment details. Don't have a copy? Ask your agent or contact us.
- If you're enrolling in an HMO plan, you must choose a Primary Care Physician (PCP). View a list of doctors for your plan on anthem.com or call us. If you don't choose a PCP, we'll pick one located close to you.

Some frequently asked questions

1. **Do I need to include a payment?**
   Yes. We can't process your application without your first month's premium payment. Without it, your enrollment will be delayed. We won't charge your card or cash your check or money order until you've been enrolled.
2. **What if I already have coverage with another company?**
   Don't cancel your other coverage yet — your health coverage is too important. We'll contact you when you're approved. Then you'll need to cancel your other coverage.
3. **Why do you need my Social Security Number (SSN)?**
   The IRS requires us to collect it. It won't be shared unless required by law.
   If you enroll in a health savings account (HSA) compatible plan with us, we may give it to our HSA banking partner.

Colorado Individual Application Supplement Form

Please indicate the reason for this application:
☐ Open Enrollment
☐ Special Enrollment Period (also complete Appendix A)

Step 1: Who is applying?

☐ New coverage

☐ Change coverage
☐ Add dependent to existing coverage

Subscriber ID no. _____

Primary Applicant

Last name (legal name)	**First name** (legal name)	**M.I.**	**Date of birth** (mm/dd/yyyy) / /

Legal resident of CO ☐ Yes ☐ No

Email address: _____

I'm providing my email address because **I, and my enrolled dependents, want to receive information about our benefits electronically.** These communications may include Identification (ID) Cards, Contracts or Certificates of Coverage, billing invoices, Explanation of Benefits, required notices including cancellations and renewals, and helpful or specific personalized information to help get the most out of the benefits. I understand I need to register on anthem.com or the Anthem mobile app to get the most out of my plan's digital tools, and I will make sure Anthem has my most up to date email address. I, and my enrolled dependents, understand that we can update our email addresses, change our communication preferences, and request free copies of any materials at any time by going to anthem.com or calling the Member Services number on my ID Card.

Preferred written language	**Preferred spoken language**
☐ English (ENG) ☐ Spanish (SPA)	☐ English (ENG) ☐ Spanish (SPA)

☐ Applicant DOES speak, read and/or write English.
If applicant does not speak, read or write English, the interpreter must sign and submit a "Statement of Accountability" (Appendix B).

PCP	**PCP ID**	**Current patient** ☐ Yes ☐ No	**Medical group ID**

Coverage(s) selected ☐ Medical ☐ Dental ☐ Vision
To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.
If the primary applicant selects medical coverage, all family members listed on this application will be enrolled in the medical coverage.

Eligibility

The answers to these questions are needed to determine your eligibility.

Are any applicants currently incarcerated (with more than 60 days left to serve before release) as a result of a conviction? (not just pending disposition of charges) ☐ No ☐ Yes **If yes, who?**

Are you covered for medical assistance through the state Medicaid program, Health First Colorado:
☐ No ☐ Yes **If yes, please indicate your eligibility:**
☐ Specified Low Income Medicare Beneficiary (SLMB)
☐ Qualified Medicare Beneficiary (QMB)
☐ Other Medicaid medical benefits (please explain) _____

Step 2: What coverage would you like?

Medical Plans

Choose only one medical plan. If you select an HMO product, be sure to select a Primary Care Physician (PCP) in Step 1.

Additional plan options may be available. Please write in the medical plan name and contract code if not listed below.
☐ _____

Applicants must reside in Colorado to enroll in **Pathway HMO** plans.

Anthem Bronze Pathway HMO	**Anthem Silver Pathway HMO**
☐ 5650 Rx Copay $0 Select Drugs (6RWA) ☐ 6000 $0 Select Drugs (6RUH) ☐ 7450 for HSA (6RWW) ☐ 9100 $0 Select Drugs (6RWC)	☐ 2800 30% $0 Select Drugs (6RVR) ☐ 3000 for HSA 20% (6SC1) ☐ 3500 Rx Copay 15% $0 Select Drugs (6RTU) ☐ 5000 35% $0 Select Drugs (6RUU) ☐ 6500 Rx Copay 40% $0 Select Drugs (6RUB)

Anthem Catastrophic Pathway HMO	Only available to applicants under age 30, unless otherwise qualified.
☐ 9100 (6RU3)	

Applicants must reside in one of these counties to enroll in **Pathway Essentials HMO** plans: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, or Park.

Anthem Bronze Pathway Essentials HMO	**Anthem Silver Pathway Essentials HMO**
☐ 5650 Rx Copay $0 Select Drugs (6RVE) ☐ 6000 $0 Select Drugs (6RTM) ☐ 7450 for HSA (6RUZ) ☐ 9100 $0 Select Drugs (6RUF)	☐ 2800 30% $0 Select Drugs (6RT1) ☐ 3000 for HSA 20% (6SBD) ☐ 3500 Rx Copay 15% $0 Select Drugs (6RVW) ☐ 5000 35% $0 Select Drugs (6RV7) ☐ 6500 Rx Copay 40% $0 Select Drugs (6RUS)

Anthem Catastrophic Pathway Essentials HMO	Only available to applicants under age 30, unless otherwise qualified.
☐ 9100 (6RTT)	

Applicants must reside in one of these counties to enroll in **Mountain Enhanced HMO** plans: Archuleta, Eagle, La Plata, Mesa, Moffat, Montezuma, Rio Blanco, Routt, or Summit.

Anthem Bronze Mountain Enhanced HMO	**Anthem Silver Mountain Enhanced HMO**
☐ 5650 Rx Copay $0 Select Drugs (6RTH) ☐ 6000 $0 Select Drugs (6RWX) ☐ 7450 for HSA (6RWU) ☐ 9100 $0 Select Drugs (6RU2)	☐ 2800 30% $0 Select Drugs (6RUG) ☐ 3000 for HSA 20% (6SBW) ☐ 3500 Rx Copay 15% $0 Select Drugs (6RTS) ☐ 5000 35% $0 Select Drugs (6RWQ) ☐ 6500 Rx Copay 40% $0 Select Drugs (6RW8)

For Colorado Standard Option plans, please select from the following plans: Pathway Standard HMO, Pathway Essentials Standard HMO, and Mountain Enhanced Standard HMO.

Applicants must reside in any Colorado county to enroll in **Pathway Standard HMO** plans except: Adams, Arapahoe, Archuleta, Boulder, Broomfield, Clear Creek, Denver, Douglas, Eagle, Elbert, Gilpin, Jefferson, La Plata, Mesa, Moffat, Montezuma, Park, Rio Blanco, Routt, or Summit.

Anthem Colorado Option	
☐ Bronze Pathway Std (6SCL)	☐ Silver Pathway Std (71LU)

Applicants must reside in one of these counties to enroll in **Pathway Essentials Standard HMO** plans: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, or Park.

Anthem Colorado Option	
☐ Bronze Pathway Essentials Std (6SCW)	☐ Silver Pathway Essentials Std (71LY)

Applicants must reside in one of these counties to enroll in **Mountain Enhanced Standard HMO** plans: Archuleta, Eagle, La Plata, Mesa, Moffat, Montezuma, Rio Blanco, Routt, or Summit.

Anthem Colorado Option	
☐ Bronze Mountain Enhanced Std (6SBS)	☐ Silver Mountain Enhanced Std (71LV)

Health Savings Account (HSA) Enrollment	If you choose an HSA compatible plan, please select one of the options below:

☐ I request that Anthem facilitate opening my HSA with its service provider and, as part of that transaction, I understand Anthem will disclose my name, SSN, and claims data, and that of my dependents if applicable, to its service provider to support my HSA.
☐ I request that Anthem NOT facilitate opening an HSA with its service provider for me.

Current medical coverage	If you already have healthcare coverage, please don't cancel it until you are effective with us.

Important information about replacement and duplicate coverage:
Normally you do not require more than one of the same type of policy, but if you purchase this policy, you may want to evaluate your existing health insurance and decide if you need multiple coverages. You may be eligible for benefits under Medicaid or Medicare and may not need another health insurance policy. If you are eligible for Medicare, you may want to purchase a Medicare supplement insurance policy. If you are eligible for Medicare due to age or disability, counseling services are available in Colorado to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, Health First Colorado.

☐ One or more of the applicants currently have healthcare coverage (Please fill out the info below.)

Name of person covered (Last, First, M.I.)	**Coverage Type**	**Insurer name**	**Policy ID no.**	**Coverage Dates (if applicable) (mm/dd/yyyy) Termination Date (if different from coverage end date)**
	☐ Group ☐ Individual			**Start:** / / **End:** / / **Termination Date:** / /
	☐ Group ☐ Individual			**Start:** / / **End:** / / **Termination Date:** / /
	☐ Group ☐ Individual			**Start:** / / **End:** / / **Termination Date:** / /
	☐ Group ☐ Individual			**Start:** / / **End:** / / **Termination Date:** / /
	☐ Group ☐ Individual			**Start:** / / **End:** / / **Termination Date:** / /

Will you be terminating this coverage if approved for Anthem coverage? ☐ No ☐ Yes
If Yes, do you intend to replace your current health insurance with this policy (contract)? ☐ No ☐ Yes
If Yes, please read the following: According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield or HMO Colorado. Your new policy will provide 10 days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Dental Plans

Dental coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a dental plan if you want to buy coverage for more than these Pediatric Dental Essential Health Benefits.

Dental plan options

- ☐ Anthem Dental Family Value (673X)
- ☐ Anthem Dental Family (673V)
- ☐ Anthem Dental Family Enhanced (673W)
- ☐ Essential Choice Basic (5SFQ)
- ☐ Essential Choice Select (5SFR)
- ☐ Essential Choice Classic (5SFS)
- ☐ Essential Choice Premier (5SFT)
- ☐ Essential Choice Incentive (5SFU)

Prior and other dental coverage

Name of person covered (Last, First, M.I.)	Coverage (check all that apply)	Insurer name	Policy ID no.	Dates (if applicable) (mm/dd/yyyy)
	☐ Dental ☐ Orthodontia			**Start:** / / **End:** / /
	☐ Dental ☐ Orthodontia			**Start:** / / **End:** / /
	☐ Dental ☐ Orthodontia			**Start:** / / **End:** / /
	☐ Dental ☐ Orthodontia			**Start:** / / **End:** / /
	☐ Dental ☐ Orthodontia			**Start:** / / **End:** / /

Will you be terminating this coverage if approved for Anthem coverage? ☐ No ☐ Yes

If Yes, do you intend to replace your current dental insurance with this policy (contract)? ☐ No ☐ Yes

If Yes, please read the following: According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield or HMO Colorado. Your new policy will provide 10 days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all dental coverage you now have. If, after due consideration, you find the purchase of this dental coverage is a wise decision you should evaluate the need for other dental coverage you have that may duplicate this policy.

Vision Plans

Vision coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a vision plan if you want to buy coverage for more than these Pediatric Vision Essential Health Benefits.

Vision plan options

- ☐ Blue View Vision Bundled (1RY2)
- ☐ Blue View Vision Value (2SUL)
- ☐ Blue View Vision Plus (2SUK)
- ☐ Blue View Vision Enhanced (2SUJ)
- ☐ Blue View Vision Basic (5LC0)
- ☐ Blue View Vision Premier (5LEY)
- ☐ Blue View Vision Ultra (5LDG)
- ☐ Blue View Progressive Select (5LD1)
- ☐ Blue View Progressive Preferred (5LCN)

Statement to applicant by issuer or producer

For Non-Health Benefits Plans: If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Applicant's signature	**Date** (mm/dd/yyyy) / /

Premium Reimbursement

1. Will an employer of one hundred (100) or fewer eligible employees be paying for or reimbursing you through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for? ☐ No ☐ Yes **If you answered yes, please continue. If you answered no, please proceed to Step 3.**
2. If the employer will be reimbursing you through a health reimbursement arrangement, does it qualify as a QSEHRA (Qualified Small Employer Health Reimbursement Arrangement) or ICHRA (Individual Coverage Health Reimbursement Account)?** ☐ No ☐ Yes
3. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve (12) months prior to the date of this application? ☐ No ☐ Yes

If the answer to both questions 1 and 3 immediately above is "yes" and the answer to question 2 is "no", you may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

You must submit a signed affidavit from the employer, If:
The answer to questions 1 and 2 is "yes" and the answer to question 3 is "no" or
The answer to question 1 is "yes" and the answer to questions 2 and 3 is "no".

The affidavit form to be executed by the employer is Appendix C at the end of this form. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier. I'm applying for individual health and/or dental and/or vision coverage which is not part of any employer sponsored plan and I'm responsible for all of the premium payments and making sure that all premiums are paid on time.
**Employers are required by 26 U.S.C. 9831(d)(4) to provide employees written notice regarding QSEHRAs and ICHRAs.

Step 3: Please read and sign

Important legal information

I, the undersigned, understand that under the Anthem plan for which I am applying, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use an in-network hospital or physician.

- I must include my first premium payment with this application, but that does not mean coverage has been approved. I'm applying for the coverage I chose in Step 2. To the extent permitted by law, Anthem has the right to accept or decline this application. If my application is denied, my bank account or credit card will not be charged, and if I paid with a money order, it will be returned to me.
- I'm responsible to let Anthem know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- I agree to pay the premium due. I also agree to pay for any fee or charge Anthem bills me as part of an exchange fee, assessment, uninsured pool or other state or federal program. I agree that my payments will be first applied to such fees or assessments and the balance applied to premium.
- Check payments may be handled as Automated Clearinghouse (ACH) debit transactions. That means if I pay by check, the paper check will be destroyed and the debit payment will appear on my bank statement. My check won't be given to my financial institution or sent back to me. This does not mean I will be enrolled in an automatic debit process to pay my premium. Any resubmissions due to insufficient funds may also be electronic. All checking transactions will remain secure, and my payment by check means I agree to these terms.
- I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and me.
- By providing a phone number, I agree and consent that Anthem and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.
- I certify that each Social Security Number listed on this application is correct.
- My domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is at least 18 years of age; he or she is mentally competent; he or she is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
- I represent that I have read the Important Legal Information section, and I agree to the coverage conditions. I represent the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).

I sign this application for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative. This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

Rescission of Membership
I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered in this application, Anthem may revoke my coverage. This means Anthem may cancel membership as if it never existed. Also, after approval for membership, if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered by Anthem that was not provided to Anthem prior to the effective date of the policy, the plan may revoke coverage.

I understand that if my coverage is revoked, I will be sent written notice that will explain the basis for the decision and my appeal rights. I also understand that I may be required to pay for any claims that were paid while a member and that Anthem will refund all amounts paid by me except amounts owed to Anthem.

I have personally read and completed this application. If I am accepted, this application will become part of the contract between Anthem and me. I agree to abide by the terms of that contract.

By signing this application, I certify that the premium for my coverage will not be paid by a provider of healthcare services, hospital, non-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entity with a direct or indirect financial interest in the benefits of the contract/policy, or an employer that offers coverage under an employer health plan. I understand that if a third party is paying my premium, Anthem may decline to accept such premium payment if it is made by a person or entity from which it is not required by law to accept.

REQUIREMENT FOR BINDING ARBITRATION:

I UNDERSTAND AND AGREE THAT ANY AND ALL DISPUTES BETWEEN ANTHEM AND MYSELF MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE AFFORDABLE CARE ACT. ANTHEM AND I AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN OUR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT ANTHEM AND I ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

BEFORE COMMENCING ARBITRATION, THE PARTY SEEKING ARBITRATION MUST HAVE EXHAUSTED ALL LEVELS OF APPEAL AND REVIEW SET FORTH IN THE CERTIFICATE. ANY SUCH ARBITRATION WILL BE GOVERNED BY THE PROCEDURES AND RULES ESTABLISHED BY THE AMERICAN ARBITRATION ASSOCIATION. THE LAW OF THE STATE IN WHICH THE POLICY WAS ISSUED AND DELIVERED TO THE POLICYHOLDER SHALL GOVERN THE DISPUTE. THE DECISION IN ARBITRATION IS BINDING UPON BOTH ANTHEM AND ME. THE AWARD GIVEN IN ARBITRATION MAY BE ENFORCED OR REVIEWED IN ANY COURT THAT HAS PROPER JURISDICTION. IN THE EVENT ANY PERSON SUBJECT TO THIS ARBITRATION CLAUSE INITIATES LEGAL ACTION OF ANY KIND, THE OTHER PARTY MAY APPLY FOR A COURT OF COMPETENT JURISDICTION TO ENJOIN, STAY OR DISMISS ANY SUCH ACTION AND DIRECT THE PARTIES TO ARBITRATE IN ACCORDANCE WITH THIS PROVISION. THE QUESTION OF WHAT DISPUTES ARE SUBJECT TO THIS ARBITRATION CLAUSE SHALL BE DETERMINED BY THE ARBITRATOR.

IF AN APPLICANT DOES NOT READ ENGLISH, THE TRANSLATOR MUST SIGN AND SUBMIT A STATEMENT OF ACCOUNTABILITY FOR TRANSLATING THIS ENTIRE APPLICATION (SEE APPENDIX B).

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING, BY THE EXTENT PERMITTED BY STATE OR FEDERAL LAW, TO HAVE ANY AND ALL DISPUTES AGAINST ANTHEM BLUE CROSS AND BLUE SHIELD DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO JURY OR COURT TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS AND ANY OTHER DISPUTES. SIGNATURES REQUIRED.

Please sign below

	Primary Applicant (or legal representative)	Date (mm/dd/yyyy) / /
	Spouse/Domestic Partner (or legal representative)	Date (mm/dd/yyyy) / /
	Dependent Child (age 18 or over)	Date (mm/dd/yyyy) / /
	Dependent Child (age 18 or over)	Date (mm/dd/yyyy) / /
	Dependent Child (age 18 or over)	Date (mm/dd/yyyy) / /

Did an agent or broker help you?

☐ Yes ☐ No If yes, make sure they fill out this section.

Agent (or Broker) Certification All fields required.

I have listed above any policies or contracts I sold the applicant which are current and any policies or contracts I sold in the past five (5) years.
I certify to the best of my knowledge and belief, the responses herein are accurate.

I have reviewed your current accident and sickness insurance coverage, which provides comprehensive medical coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

☐ Additional benefits ☐ No change in benefits, but lower premiums ☐ Fewer benefits and lower premiums
☐ Other (please specify) _____

Agent/Broker signature	**Date** (mm/dd/yyyy) / /
Agent name (please print clearly)	

***(A) Writing Agent TIN/SSN** (encrypted TIN is ok)	****(B) Writing Agent/Agency/General Agency TIN** (encrypted TIN is ok)

Agent address	**City**	**State**	**ZIP**

Agent phone no.	**Agent fax no.**	**Agent email**

***Field (A)** — Always provide your Writing Agent TIN/SSN. ****Field (B)** — If you are a Direct Agent, with no relationship to an Agency, also enter your Agent TIN/SSN in Field (B). If this policy is sold through an Agency without a General Agency, enter the selling Agency TIN in Field (B); if this policy is sold through a General Agency, enter the General Agency TIN in Field (B).

Medical only: For information on how your broker is compensated, please visit anthem.ly/co-aca-32337.

Here's what's next.

1) Can you check a few items? When illegible or missing, they can cause enrollment delays.
   - Your name and address is clear and complete.
   - You've included your first month's premium payment.
   - Everyone 18 and older applying for coverage signed this form.
   - Please make sure you submit all the pages of the application, including this page, even if you don't have an agent.
   - If enrolling due to a qualifying event, you've completed Appendix A: Special Enrollment.

2) All good? Send this to us by mail to Anthem Blue Cross and Blue Shield, P.O. Box 659960, San Antonio, TX 78265-9146 or by fax to 1 (800) 848-2512.

3) We'll be in touch in the next few weeks (or sooner). If you have questions before then, call us at 1 (855) 383-7249.

Thank you!

Appendix A: Special Enrollment

If you're applying for coverage due to a qualifying event, please fill out this section along with your application.

Qualifying event date	
Date of qualifying event (mm/dd/yyyy) / /	For Loss of Coverage, this is the last date of existing or prior coverage. For all other events, please enter the date based on the qualifying event.

You must apply for coverage within 60 days after your qualifying event for the following events. If you have existing coverage and are adding one or more dependents due to marriage, birth, or adoption, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) who doesn't have current coverage.

For qualifying events that allow a self-attestation instead of supporting documentation, I am attesting to my eligibility by selecting the box on this form for the qualifying event that is applicable to me.

Qualifying events	Coverage effective date
1. Marriage/Civil Union or Domestic Partnership ☐ Got married, entered into a civil union, or into a domestic partnership that becomes eligible for coverage (see step 3 for description of domestic partnership eligibility). One or both of the spouse(s)/domestic partner(s) must have had Minimum Essential Coverage for one or more days in the 60 days prior to the marriage/civil union/domestic partnership, unless one or both of the individuals has moved from a foreign country or U.S. territory within the 60 day period before the marriage/civil union/domestic partnership. ☐ Got married, entered into a civil union, or into a domestic partnership that becomes eligible for coverage (see step 3 for description of domestic partnership eligibility). I attest that I am an Indian, as defined by Section 4 of the Indian Health Care Improvement Act. Supporting documentation for the marriage/civil union/domestic partnership must be provided. ☐ Got married, entered into a civil union, or into a domestic partnership that becomes eligible for coverage (see step 3 for description of domestic partnership eligibility). I attest that I lived one or more days in a service area where no Qualified Health Plan was available through the Exchange, within 60 days prior to the qualifying event or during the most recent preceding enrollment period. Supporting documentation for the marriage/civil union/domestic partnership must be provided.	First day of the month after we receive your complete application
☐ **2. Birth or adoption** Had a baby, adoption of a child or placement of a child with you for adoption	**Select an effective date:** ☐ Same as the event date ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application* ☐ First day of month after the event date
☐ **3. Court order or guardianship** Required by a court order to provide an eligible child(ren) coverage, including a child support order, filed an application for appointment of guardianship of a child or appointment of guardianship of a child	**Select an effective date:** ☐ Same as the event date ☐ Based on when we receive your complete application*

* If the coverage date is based on when we receive your complete application, then if we receive it:

- Between the 1st and 15th day of the month, coverage starts the 1st day of the following month.
- Between the 16th and the last day of the month, coverage starts the 1st day of the second following month.

Qualifying events	Coverage effective date
☐ **4. Death** Death of a family member enrolled under current coverage	**Select an effective date:** ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application*
☐ **5. Immigration** Immigration status changed ☐ **6. Other qualifying event** If you can't find your situation, contact your agent/broker or call us. We can only enroll based on events defined by state and/or federal law.	Based on when we receive your complete application*

You must apply for coverage within 60 days before or 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
7. Loss of coverage: Lost or will lose Minimum Essential Coverage: ☐ Involuntary loss of coverage (for any reason except non-payment of premium or fraud) ☐ Change in employment status ☐ Exhaustion of COBRA or state continuation benefits ☐ Loss of dependent status ☐ A legal separation or divorce ☐ Moved to a new service area. Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move. ☐ Other: _____	First day of the month after we receive your complete application
8. Permanent move ☐ Moved to U.S. from a foreign country or a U.S. territory ☐ Permanent move to a new service area (within the U.S.). Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move. ☐ Permanent move to a new service area (within the U.S.). I attest that I am an Indian, as defined by Section 4 of the Indian Health Care Improvement Act. ☐ Permanent move to a new service area (within the U.S.). I attest that I lived one or more days in a service area where no Qualified Health Plan was available through the Exchange, within 60 days prior to the qualifying event or during the most recent preceding enrollment period. ☐ **9. Non-calendar renewal** Current policy does not renew on a calendar year basis (renews on a date other than January 1) ☐ **10. Jail or prison** Released from jail or prison (incarceration)	Based on when we receive your complete application*

* If the coverage date is based on when we receive your complete application, then if we receive it:

- Between the 1st and 15th day of the month, coverage starts the 1st day of the following month.
- Between the 16th and the last day of the month, coverage starts the 1st day of the second following month.

Qualifying events	Coverage effective date
☐ **11. ICHRA or QSEHRA** Offered or gained access to Individual Coverage Health Reimbursement Arrangement (ICHRA)/Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) during your employer's annual open enrollment period or because of a change in employee status	If we receive your complete application before the qualifying event date: • Coverage will be effective on the qualifying event date if the qualifying event occurs on the first day of a month • Coverage will be effective on the first day of the month after the qualifying event if the qualifying event does not occur on the first day of a month If we receive your complete application on or after the qualifying event date: • Coverage will be effective on the first day of the month after receipt of your complete application

Almost there! We may need a bit more info.

We need supporting documentation for most qualifying events, such as a letter or official form from the source (employer, state or federal agency, for example) to confirm the qualifying event occurred. It should also include the date the event happened, and the names of all applicants affected. We reserve the right to request additional documentation as required.

Give us or your agent a call if you have any questions.

Appendix B: Statement of Accountability

Statement of Accountability Fill out when applicant cannot complete application.

Note: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I, _____, personally read and completed this Individual Application for the applicant named below because:

- ☐ Applicant does not read English
- ☐ Applicant does not speak English
- ☐ Applicant does not write English
- ☐ Applicant is Limited English Proficient
- ☐ Other (explain) _____

I interpreted the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the

- ☐ Applicant or by: _____

Language interpreted

☐ Spanish ☐ Chinese ☐ Korean ☐ Tagalog ☐ Vietnamese ☐ Other _____

I also interpreted and fully explained the "Important legal information" and the "Payment Method".

Signature of interpreter (required)	**Date** (mm/dd/yyyy) (required) / /
I confirm that the application was interpreted on my behalf	
Signature of applicant (required)	**Date** (mm/dd/yyyy) (required) / /

Appendix C: Employer Affidavit

Employer's Information Complete if required based on Premium Reimbursement section of this application.

Name			
Street address	**City**	**State**	**ZIP**

The undersigned officer or principal of the employer identified above certifies that:

1. The employer is a small employer as defined in § 10-16-102(61), C.R.S., with one hundred (100) or fewer eligible employees;
2. The employer has either not had in place a small group health benefit plan for the twelve (12) months prior to the execution of this affidavit or that it is using a qualified small employer health reimbursement arrangement (QSEHRA) to reimburse its employees' individual health insurance premiums.

A false certification may cause the rescission of the employee's individual health insurance policy and subject the employer to penalties for perjury and liability to the employee.

Signature	**Printed name**	**Position**	**Date** (mm/dd/yyyy) / /

Payment Methods for Individual Applications

Anthem

Applicant/Member name	Primary applicant's Social Security number

Anthem Blue Cross and Blue Shield (Anthem) will accept monthly payments on behalf of applicants/members **if the payment is made by the following persons or entities:** The Ryan White HIV/AIDS Program; other federal and state government programs that provide monthly payments and cost-sharing support for specific individuals; Indian tribes, tribal organizations and urban Indian organizations; or a relative or legal guardian on behalf of an applicant/member.

Unless required by law, Anthem does not accept monthly payments from third parties that are not listed above. Examples of third parties from whom Anthem will not accept monthly payments include, but are not limited to, insurance brokers and/or agents, doctors, hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entities with a direct or indirect financial interest in the benefits of the contract/policy and employers that offer coverage under an employer health plan. Note: As allowed by law, Anthem reserves the right to decline monthly payments from third parties.

I authorize Anthem to debit the bank account listed or charge the credit/debit card listed for my first monthly payment on or after the day that my coverage is approved. By signing this form, I understand that the amount of the first payment may change from what I was told because my coverage has not been approved yet. In addition if I select Option 1 or Option 2 below, I understand that my future payments may vary as a result of changes(s) I make once enrolled, including but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified according to my plan/policy. In addition, I understand if changes I make are close to the auto withdrawal date, Anthem may not be able to notify me before the withdrawal is made. **I agree to pay any service charge that Anthem may bill me because the debit/charge was not honored.** I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Please choose how you want to pay your monthly payments for all of your plans. Put a check in the box for either Option 1, Option 2 or Option 3.

☐ **Option 1 Bank Account Authorization: Have your first and future monthly payments automatically deducted from your bank account.**

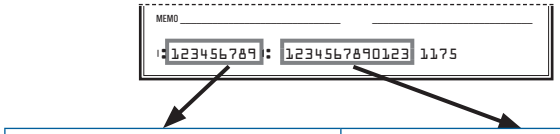
All of your monthly payments will be taken out of the **bank account** you check below.

Checking account: ☐ Business ☐ Personal

Savings account: ☐ Business ☐ Personal

Enter the requested debit date from your bank account ___ (1st to 6th of each month). If no date is requested your monthly payments will be debited on the first of each month.

Write the routing and account numbers that are on your check here: →



9-digit bank routing number	Bank account number

I authorize Anthem to automatically debit the **bank account** listed above each month to make my monthly payments. I agree that **Anthem's rights with each debit are the same as if the debit was a check that I signed**. I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem to automatically debit my account (and to make corrections to previous debits). This authority stays in effect until I let Anthem know that I no longer want them to debit my account by giving them a 30-day advance written notice. I understand that if my bank does not allow Anthem to debit my account for any reason, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Authorized signature (as it appears on bank's records) X	Printed bank account holder's name (as it appears on account)	Date (MM/DD/YY)

☐ **Option 2 Credit/Debit Card Authorization: Have your first and future monthly payments automatically charged to your credit/debit card.**

Complete the information below

Enter the requested charge date for your credit/debit card ___ (1st to 6th of each month).

I authorize Anthem to automatically charge my **credit/debit card** listed below each month to make my monthly payments. I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem to charge my credit/debit card until I let them know that I no longer want them to charge my credit/debit card by giving them a 30-day advance written notice. I agree that Anthem, in honoring the monthly payments charged to my credit/debit card, is not responsible for any fees charged by my bank. I understand if that if any Anthem credit/debit transaction is not honored, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Anthem accepts ☐ **Visa or** ☐ **Mastercard (Note to applicant: Please check one.)**

Card number	Expiration date ___ (MM/YY)	
Billing address for this credit/debit card	**City**	**Zip code**
Authorized signature (as it appears on card) X	**Printed card holder's name (as it appears on card)**	**Date (MM/DD/YY)**

See page two for *Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.*

Payment Methods for Individual Applications

Applicant/Member name	Primary applicant's Social Security number

☐ **Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.**

Choose one of the ways below that you would like to pay only your first monthly payment.

☐ Check (enclose your paper check with application) ☐ Electronic check (fill out section A below) ☐ Credit/Debit card (fill out section B below)

A. **Electronic check:** Instead of sending us a paper check, you can use an electronic check that allows Anthem to take the money right from your bank account to make your first payment on the day that your coverage is approved. You will not get the check back from your bank. (We will not keep this information on file or use it for any future payments.) Please fill out this information.

Printed account holder name	Routing number	Account Number	Amount of first payment
			$

B. **Credit/Debit card:** I allow Anthem to charge the credit or debit card I listed below one time for my first monthly payment. This payment will cover the first monthly payment for all of the plans I have with Anthem.

Anthem accepts ☐ Visa or ☐ Mastercard (Note to applicant: Please check one.)

Card number	Expiration date (MM/YY)

Billing address for this credit/debit card	City	Zip code

I authorize Anthem to debit/charge the bank account or credit/debit card listed above **to make my first monthly payment only.**

I agree that Anthem will not have to pay any fees that my bank may charge because my electronic check or credit/debit card was rejected even if I can no longer continue coverage. I understand that **this is a one-time payment and that I am responsible for making sure Anthem receives my future monthly payments after this first payment.**

Authorized signature (as it appears on bank account/card)	Printed bank account/card holder's name (as it appears on account/card)	Date (MM/DD/YY)
X		

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ iਵੱਚ ਮੁਫ਼ਤ iਵੱਚ ਮਦਦ ਹਾiਸਲ ਕਰਨ ਦਾ ਿਅਧਕਾਰ ਹੈ। ਬਸ ਆਪਣy ਆਈਡੀ ਕਾਰਡ ਤੇ iਦੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. 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 in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to 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. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Information for Applicants Requesting a Special Enrollment Period

When applying to enroll for coverage during a Special Enrollment Period (SEP), an applicant must be eligible to enroll and provide supporting documentation of a qualifying event. Without this documentation the applicant may not be able to enroll.

Please review the list below which outlines examples of what may be used as supporting documentation. Be sure to send in a copy of the documentation supporting the qualifying event when the completed application is submitted or upload a copy of the documentation when submitting an online application.

For paper applications, please submit legible copies of everything and keep all original documents for your personal records, because no documentation will be returned. Please write the applicant's name on the top of each page of the supporting documentation.

After reviewing the information provided, we may request additional documentation to confirm eligibility. Please note that loss of health coverage due to fraud, intentional misrepresentation of a material fact or failure to pay a premium do not constitute qualifying events.

Please note: Anthem will notify the applicant within 14 days of receipt of the application if the applicant did not provide sufficient documentation necessary to verify eligibility for the special enrollment/triggering event requested. The applicant will then have 30 days from that notice to provide us with sufficient documentation to establish eligibility for the special enrollment/triggering event and we will make a determination within 14 days of receiving that documentation.

If you have further questions about qualifying events or the supporting documentation that is required, please call your agent or customer service at 1-855-383-7249.

Supporting documentation by type of qualifying event
For all SEP applicants for Anthem Blue Cross and Blue Shield plans in Colorado

Qualifying Event	Description and examples of supporting documentation
Lost or will lose Minimum Essential Coverage: Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay a premium	**Loss of Minimum Essential Coverage due to any of the following:** ○ Change in employment status ○ Loss of dependent eligibility status due to: • Death • Medicare Enrollment • An overage dependent • Legal separation, divorce, dissolution of domestic partnership or civil union • Exhaustion of COBRA or state continuation benefits **Applicants will self-attest by submitting the application (including Appendix A "Special Enrollment", for Off Exchange applicants who are using the Supplemental Application).**
Permanent move to new service area	*Note: Applicant must have had Minimum Essential Coverage for one or more days in the 60 days prior to the permanent move. Refer to Application for information regarding applicants who may be exempt from the Minimum Essential Coverage requirement.* ○ Applicants will self-attest by submitting the application (including Appendix A "Special Enrollment", for Off Exchange applicants who are using the Supplemental Application).
Required by a court order to provide an eligible child(ren) coverage, including a child support order, appointment of guardianship of a child or a child in foster care is placed with you	Legal documentation of guardianship that indicates the subscriber or the subscriber's spouse is a guardian of the applicant or court order that indicates the subscriber is required to cover the applicant. Contact us if you are applying for a child only policy.

Qualifying Event	Description and examples of supporting documentation
Had a baby, adoption of a child or placement of a child with you for adoption	**Birth:** Birth certificate **or** medical records from hospital or pediatrician which indicate the names of the parents, the name of the baby, and date of birth. NOTE: *For current Anthem members, a mother's delivery claim may be considered as supporting documentation.* **Adoption/placement for adoption:** Adoption certificate or document establishing placement of a child with applicant for adoption.
Got married, entered in a civil union or in a domestic partnership that becomes eligible for coverage	Certificate of marriage, domestic partnership or civil union. ***Note: At least one spouse or domestic partner must demonstrate that they had Minimum Essential Coverage for one or more days in the 60 days prior to the date of the qualifying event. Refer to Application for information regarding applicants who may be exempt from the Minimum Essential Coverage requirement.***
Moved to the U.S. from a foreign country or U.S. territory	Applicants will self-attest by submitting the application (including Appendix A "Special Enrollment", for Off Exchange applicants who are using the Supplemental Application).
Applicant becomes newly eligible, or his or her dependent becomes newly eligible, for enrollment in a QHP through the Exchange because they have been released from incarceration	Papers from local, state or federal department of corrections or prisons showing the applicant's date of legal discharge.
Death of an Enrollee, or his or her dependent	Copy of death certificate or obituary, **and** Document showing dependent relationship (birth certificate, information from insurance company, legal document) if not already included in above documentation.
Immigration status changed	Change in status validated by any of the following: • Valid U.S. passport or passport card • Valid I-551, permanent resident card (issued by the Department of Homeland Security/U.S. citizenship and immigration services). Non-expiring I-551 (issued 1977-1989) cards are acceptable. • U.S. Certificate of Naturalization (federal form N-550). • Certificate of U.S. Citizenship (federal form N-560). • Employment Authorization Document • Unexpired foreign passport with a valid unexpired U.S. visa affixed accompanied by the approved I-94 form documenting the applicants most recent admittance into the U.S.
When an Exchange enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs	Copy of legal separation agreement, divorce decree or notarized legal termination of domestic partnership or civil union **and** Document showing dependent relationship (birth certificate, information from insurance company, legal document) if not already listed in above documentation.
Newly eligible or ineligible for the federal advance payment tax credit or has a change in eligibility for cost-sharing reductions available through the Exchange	Applicants will self-attest by submitting the application (including Appendix A "Special Enrollment", for Off Exchange applicants who are using the Supplemental Application).
Current policy does not renew on a calendar year basis (renews on a date other than January 1st)	Information from previous carrier (recent billing statement, ID card, renewal letter) confirming coverage (date and individuals) and renewal date of coverage.

Qualifying Event	Description and examples of supporting documentation
An individual who is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR § 1.36B-2T, including a dependent or unmarried victim within a household, who is enrolled in creditable coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; **An individual who is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;**	Statement that the applicant(s) (which can include any dependent or unmarried victim within the same household) is currently enrolled in creditable coverage with the perpetrator of the abuse or abandonment. The statement can be provided to us over the phone or via email. Please call us to confirm if this is your qualifying event.
An individual or his or her dependent loses pregnancy-related Medicaid coverage. **A parent or legal guardian dis-enrolling a dependent, or a dependent becoming ineligible for the Child Health Plan Plus (CHP+);** **An individual becoming ineligible under the Colorado Medical Assistance Act (C.R.S. § 25.5-4-101 et seq.);** **Originally determined to be eligible for Medicaid or the Child Health Plan Plus (CHP+) but later determined to be ineligible after open enrollment has ended**	Applicants will self-attest by submitting the application (including Appendix A "Special Enrollment", for Off Exchange applicants who are using the Supplemental Application).
Material error in plan benefits, service area or premium influenced the applicant's decision to purchase their current plan	Applicants will self-attest by submitting the application (including Appendix A "Special Enrollment", for Off Exchange applicants who are using the Supplemental Application).
An individual's or his or her dependent's enrollment or non-enrollment in a health benefit plan that is unintentional, inadvertent or erroneous and is the result of an error, misrepresentation, or inaction of the carrier, producer, or the Exchange	Applicants will self-attest by submitting the application (including Appendix A "Special Enrollment", for Off Exchange applicants who are using the Supplemental Application).
Any other event or circumstance as set forth in the rules established by	An official form such as a letter or other supporting documentation from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected.

Qualifying Event	Description and examples of supporting documentation
applicable state or federal law in defining qualifying events.	
Employees and their dependents who gain access to an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) for the first time, or who had or were offered QSEHRA or ICHRA in the past, ceased coverage (or turned it down) and are then offered it again – either during the employer's annual open enrollment period, or because the employee switches to a different class of employees who are eligible for the coverage.	Copy of the ICHRA or QSEHRA offer.
An individual who has purchased a short-term limited duration health insurance policy in the past twelve (12) months and is unable, at the end of his or her policy term, to purchase another short-term policy from the same carrier due to that short-term policy carrier ceasing its sales of all short-term policies in Colorado.	Applicants will self-attest by submitting the application (including Appendix A "Special Enrollment", for Off Exchange applicants who are using the Supplemental Application).
Is found eligible for financial assistance for health coverage by Connect for Health Colorado, having indicated by the tax deadline on a Colorado Individual Income Tax Form that they are interested in learning more about free or reduced health coverage.	Applicants will self-attest by submitting the application (including Appendix A "Special Enrollment", for Off Exchange applicants who are using the Supplemental Application).
Did not receive timely notice of an event that triggers eligibility for a special enrollment period, and otherwise was reasonably unaware that a triggering event occurred, the Exchange must allow the individual and their dependent, to select a new	Documentation from the Exchange or other documentation demonstrating untimely notice.

Qualifying Event	Description and examples of supporting documentation
plan within 60 days of the date that they knew, or reasonably should have known, of the occurrence of the triggering event.	
Becomes eligible, or their dependent becomes eligible for advance payments of the premium tax credit and whose household income is expected to be no greater than 150% of the federal poverty level, may enroll in a QHP or change from one QHP to another one time per month during periods of time when the applicable individual's applicable percentage for purposes of calculating the premium assistance amount is set at zero.	Applicants will self-attest by submitting the application (including Appendix A "Special Enrollment", for Off Exchange applicants who are using the Supplemental Application).
In the event, an individual, or their dependent, is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the qualified individual's or dependent's COBRA continuation coverage or government subsidies completely cease. The triggering event is the last day of the period for which COBRA continuation coverage is paid for or subsidized, in whole or in part, by an employer or government entity.	Applicants will self-attest by submitting the application (including Appendix A "Special Enrollment", for Off Exchange applicants who are using the Supplemental Application).

Anthem

2023 Plan Year

Anthem Essential Choice PPO and Dental Family PPO plan rates

INDIVIDUAL DENTAL PREMIUMS IN COLORADO

For policies with effective dates January 1 through December 31, 2023

48438COMENABS DAT 06/22

Routine dental checkups are important, not only for the teeth but for overall health, too. These exams can help decrease the risk of health conditions in the mouth, such as cavities and gum disease, and also help dentists spot signs of other health conditions.* With your Anthem plan, you have access to one of the largest dental networks in the country, to help make it easier to take care of your dental health.

As part of your plan, you receive 100% coverage for preventive care, including regular dental cleanings, exams, and X-rays, when you receive care from a dentist in your plan's network. All plans cover preventive care with no waiting periods, so you can use your benefits right away.

Our Essential Choice PPO dental plans feature higher annual benefit maximums (the amount your plan will pay for dental care). You can carry over part of your unused dental benefits to the next year if you do not use all of them. Over time, this means you could double your annual maximum benefit. Essential Choice PPO dental plans also have shorter waiting periods than traditional plans for basic and major services, and our Incentive plan does not have any waiting periods.

The child/children rates shown in the charts below are defined as dependent children ages 0-18. Any enrollees age 19 and over 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 Essential Choice PPO Dental Plan monthly payments

	Basic		Select		Classic		Premier		Incentive	
	Under Age 65	Age 65 and over	Under Age 65	Age 65 and over	Under Age 65	Age 65 and over	Under Age 65	Age 65 and over	Under Age 65	Age 65 and over
Individual	$18.90	$21.15	$29.60	$33.15	$39.45	$44.20	$49.05	$54.95	$47.30	$53.00

Anthem Dental Family Value monthly payments

One adult	$9.11
One child	$13.84
One adult + one child	$22.95
One adult + two children	$36.79
One adult + three or more children	$50.63
Two adults + one child	$32.06
Two adults + two children	$45.90
Two adults + three or more children	$59.70

Anthem Dental Family monthly payments

One adult	$14.01
One child	$13.84
One adult + one child	$27.85
One adult + two children	$41.69
One adult + three or more children	$55.53
Two adults + one child	$41.86
Two adults + two children	$55.70
Two adults + three or more children	$69.54

Anthem Dental Family Enhanced monthly payments

One adult	$23.38
One child	$24.61
One adult + one child	$47.99
One adult + two children	$72.60
One adult + three or more children	$97.21
Two adults + one child	$71.37
Two adults + two children	$95.98
Two adults + three or more children	$120.59

Blue View Vision℠ monthly payments

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

Individual	$6.64
Individual + one	$11.62
Family	$18.59

Anthem

*Academy of General Dentistry. Know Your Teeth: Oral Warning Signs Can Indicate Serious Medical Conditions (accessed August 2020): knowyourteeth.com.

Blue View Vision:
Individual vision premiums for Colorado

For policies with effective dates from January 1 through December 31, 2023

Eye exams are good for more than just checking your vision. They're also an important part of caring for your overall health. Eye doctors can often find signs of conditions such as diabetes, high blood pressure, and high cholesterol. With your Blue View Vision plan, you have options for eye care and prescription eyewear needs. Our network is one of the largest in the country, so you can choose from more than 40,000 eye doctors and other eye care professionals at more than 30,000 locations.* That includes independent eye doctors, and regional or national stores, such as LensCrafters®, Target Optical®, and most Pearle Vision® locations. You will also have 24/7 access to online retailers, including Glasses.com, ContactsDirect or 1-800 CONTACTS®.

Monthly premiums

	Three Tier Structure		
Vision Plan	**Individual Only**	**Individual + 1**	**Family**
Blue View Vision Enhanced	$16.96	$29.68	$47.48
Blue View Vision Plus	$13.28	$23.24	$37.18
Blue View Vision Value	$11.00	$19.25	$30.79
Blue View Vision Progressive Preferred	$21.80	$41.42	$63.50
Blue View Vision Select	$19.39	$36.85	$56.49
Blue View Vision Basic	$16.58	$31.51	$48.31
Blue View Vision Premier	$20.42	$38.81	$59.50
Blue View Vision Ultra	$22.69	$43.12	$66.11

* NetMinder data, May 2020.

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

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