



Our plans fit your plans



SmartSense[®] Plus
Child-Only 2500
Standard Rx

Benefits SmartSense® Plus Child-Only 2500 Standard Rx

Calendar-Year Deductible	Your Choices
Individual NETWORK: \$2,500* NON-NETWORK: \$2,500*	
Network Coinsurance Options	30%
Calendar-Year Out-of-Pocket Maximum	Add Your Chosen Deductible to the Amount Below
Individual NETWORK: \$5,000 NON-NETWORK: \$9,000	
Plan Lifetime Maximum	None
Covered Services	Your Share of Costs (after deductible, unless waived)
Doctor's Office Visits	<p>NETWORK:</p> <ul style="list-style-type: none"> · First 3 Office Visits: \$30 Copay, deductible waived · Additional Office Visits: 30% Coinsurance <p>NON-NETWORK: 50% Coinsurance</p>
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	<p>NETWORK: 30% Coinsurance</p> <p>NON-NETWORK: 50% Coinsurance</p>
Inpatient Services (overnight hospital/facility stays)	<p>NETWORK: 30% Coinsurance</p> <p>NON-NETWORK: 50% Coinsurance</p>
Outpatient Services (without overnight hospital/facility stays)	<p>NETWORK: 30% Coinsurance</p> <p>NON-NETWORK: 50% Coinsurance</p>
Emergency Room Services	<p>NETWORK: 30% Coinsurance</p> <p>NON-NETWORK: 30% Coinsurance</p>
Preventive Care Services	<p>Includes preventive services recommended by the United States Preventive Services Task Force, including well child care, immunizations, PSA screenings, pap tests, and more.</p> <p>NETWORK: 0% Coinsurance, not subject to deductible</p> <p>NON-NETWORK:</p> <ul style="list-style-type: none"> · Immunizations (children under age 13): covered at no cost to member, deductible waived
Maternity	<p>NETWORK: 30% Coinsurance</p> <p>NON-NETWORK: 50% Coinsurance</p>
Optional Coverage (at additional cost)	Dental, Life
Prescription Drug Coverage	SmartSense Plus
Retail Drugs (and Mail-Order Drugs, when available)	<p>Standard Drug Coverage:</p> <p>Tier 1 (Generic drugs): \$15 Copay</p> <p>\$7,500 annual Prescription Drug deductible applies before the following:</p> <ul style="list-style-type: none"> · Tier 2 (Formulary Brand-name drugs): \$40 Copay · Tier 3 (Non-Formulary Brand-name drugs): 50% Coinsurance · Specialty: 50% Coinsurance up to a \$2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), network only and in addition to \$7,500 annual deductible <p>NON-NETWORK: Not covered</p>
Optional Drug Coverage (when available)	Not available
Other Covered Benefits include, but are not limited to:	Ambulance, Chiropractic Services, Home Health Care, Severe Mental Health, Physical/Occupational Therapy, Urgent Care
<p>IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Certificate and/or Summary of Benefits. In the event of a conflict between this Benefit Guide and either the Certificate or Summary of Benefits, the Certificate and/or Summary of Benefits will prevail.</p>	<p>*Copays/Coinsurance to network and non-network providers apply to annual out-of-pocket maximum, except where specifically noted in the Certificate.</p> <p>NOTES:</p> <ul style="list-style-type: none"> - Discounted rates apply for network-covered services. - For non-network services, the member is responsible for the coinsurance plus charges in excess of the allowable amount. - Coinsurance to network and non-network providers applies to the annual out-of-pocket maximum, except where specifically noted in the Certificate.

Give your child every advantage... Good health and a bright smile

Dental Coverage

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

Save money by using our dental network.

We have more than 1,600 participating dental PPO dentist locations in Colorado to choose from. While our dental PPO plan allows your child to go to any dentist, you may save the most money when choosing one of the dentists in our PPO provider network. Even better, when your child visits a network dentist, there is no deductible or member coinsurance for covered diagnostic or preventive services.

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

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

Non-network providers will bill members for amounts over what the member's plan pays, up to their usual charge. You will be responsible for any balance of a nonparticipating provider's bill that is more than the maximum allowed amount for nonparticipating providers, in addition to any other copays, coinsurance and deductibles.

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

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

Basic Dental Care

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

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

Major Dental Care

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

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

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

Calendar-Year Maximum Benefit

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

Term Life Insurance

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

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

Up to \$25,000 in life insurance, with no medical exams and no blood work required. Just check a box on your application and indicate your beneficiary. It's that simple.

Term life monthly rates		
Age	\$15,000 Benefit	\$25,000 Benefit
1-18	\$1.50	\$2.50



Individual health coverage

Make sure you have all the facts.

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

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

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

Ready to enroll?

Call your Anthem agent today!

After September 23, 2012, to view a Summary of Benefits and Coverage please visit healthcare.gov.

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Colorado Coverage Details

Things you need to know before you buy...



Health. Join In.™

SmartSense® Plus Child-Only 2500 Standard Rx

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

The enrollee must meet the following eligibility requirements:

- Be under 19 years of age.
- Be a permanent legal resident of Colorado.

Open Enrollment:

Open Enrollment periods occur every January 1-31 and July 1-31, followed by a 30-day waiting period with a policy effective date of March 1st or August 31st. Applications must be received during the Open Enrollment period.

Anthem must receive the application by 3 p.m. MT (5 pm ET) the last day of the Open Enrollment period.

Qualifying Events:

Applications will be processed for Child-Only plans if Anthem receives the application within 30 days of a qualifying event listed below. Coverage can start on any day of the month after the date we receive the application for a qualifying event. For example, if an application is received on October 30; the effective date can be October 31.

Qualifying events include:

- Lost employer-sponsored health insurance;
- Lost eligibility under the Colorado Medical Assistance Act or the Children's Basic Health Plan;
- Involuntarily loss of other existing coverage for any reason other than fraud, misrepresentation or failure to pay premium;
- Marriage or dissolution of marriage;
- Entry of a valid court or administrative order mandating the child be covered; or
- Birth or adoption.

The birth month of a child is not a qualifying event.

Medical Underwriting Requirement

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

- You may be offered coverage at the standard premium rate; or
- You may be offered the plan you selected at a higher rate; or
- You may not be eligible if other creditable coverage is available.

Guaranteed Renewability of All Individual Health Policies

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

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

Network Access Plan

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

Colorado Health Benefit Plan Description Form

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

Terms of Coverage

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

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

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

Access to the Medical Information Bureau (MIB)

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

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

The address of MIB's Information Office is:

**50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734**

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

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

Utilization and Case Management

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

Prospective Review/Pre-Admission Review

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

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

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

Concurrent Review

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

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

Retrospective Review

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

Case Management

Case managers are licensed health care professionals who work with you and your doctor to help you understand your benefits and support your health care needs.

Exclusions and Limitations

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

The SmartSense® Plus Child-Only 2500 Standard Rx Plan Does Not Cover:

- Acupuncture
- Autism
- Conditions covered by Workers' Compensation or similar law
- Experimental or investigative services
- Services provided by a local, state or federal government
- Services or supplies not specifically listed as covered in the Certificate
- Services received before your plan effective date or after coverage ends, except as stated in your Certificate
- Services you wouldn't have to pay for without insurance
- Services from relatives
- Any services received by Medicare benefits without payment of additional premium
- Services or supplies that are not medically necessary
- Routine exams and immunizations related to sports, insurance or condition of employment; for licensing, school, church or camp; or for routine care received in the emergency room

- Sex change operations
- Cosmetic surgery
- Services primarily for weight reduction, except medically necessary treatment for morbid obesity
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Certificate
- Hearing aids, except as specifically stated in the Certificate
- Infertility services
- Hair loss, even if there is a physician prescription and a medical reason for the hair loss
- Private duty nursing
- Eyeglasses or contact lenses
- Vision care, including certain eye surgeries to replace glasses, except as specifically stated in the Certificate
- Services received for mental and nervous disorders and substance abuse, except as specifically stated in the Certificate
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Certificate
- Services or supplies related to a pre-existing condition, for applicants age 19 and older
- Outdoor treatment programs
- Telephone, Internet or facsimile machine consultations
- Educational services, except as specifically provided or arranged by Anthem
- Nutritional counseling, food or dietary supplements, except as specifically stated in the Certificate
- Personal comfort items
- Custodial care
- Certain genetic testing
- Outpatient speech therapy, except as specifically stated in the Certificate

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

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

**Selecting health coverage
is an important decision.**

To assist you, we supply the following for the plans under consideration: Brochure, Coverage Details, Enrollment Application and Health Statement. If you did not receive one or more of these materials, please contact your Anthem Broker to request them.



Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
Colorado Individual SmartSense Plus Child-Only 2500 Standard Rx
Effective August 1, 2011

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred provider plan
2. OUT-OF-NETWORK CARE COVERED? ¹	Yes, but the patient pays more for out-of-network care
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK	OUT-OF-NETWORK
4. DEDUCTIBLE TYPE ²	Calendar Year	Calendar Year
4a. ANNUAL DEDUCTIBLE ^{2a}		
a) Single ^{2b}	\$ 2,500	\$ 2,500
b) Non-single ^{2c}	Family coverage not provided	Family coverage not provided
	Prescription drug expenses do not apply towards this deductible. Copayment amounts do not apply to the deductible.	
5. OUT-OF-POCKET ANNUAL MAXIMUM		
a) Individual ³	\$ 7,500 Includes deductible and coinsurance.	\$ 11,500 Includes deductible and coinsurance.
b) Family	Family coverage not provided	Family coverage not provided
c) Is the deductible included in the out-of-pocket maximum?	Yes	Yes
	Prescription drug expenses do not apply towards this Out of Pocket maximum. Copayment amounts do not apply to the out of pocket maximum.	
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	No lifetime limits. For benefit limits please see each applicable benefit below.	
7a. COVERED PROVIDERS	Anthem Blue Cross and Blue Shield PPO provider network. See provider directory for complete list or current providers.	All providers licensed or certified to provide covered benefits.

	IN-NETWORK	OUT-OF-NETWORK
7b. With respect to network plans, are all the providers listed in 7a accessible to me through my primary care physician?	Yes	Yes
8. MEDICAL OFFICE VISITS ⁴ a) Primary Care Providers b) Specialists	<p>\$30 copayment per office visit when included in the first three (3) office visits in a calendar year; then 30% coinsurance after deductible.</p> <p>\$30 copayment per office visit when included in the first three (3) office visits in a calendar year; then 30% coinsurance after deductible.</p> <p>Not all covered services provided through the physician's office will be included in, or paid at the same level as, an office visit. Copayment amounts do not apply to the deductible or the out of pocket maximum.</p>	<p>50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.</p> <p>50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.</p>
9. PREVENTIVE CARE a) Children's services	<p>Preventive Care Services shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, copayments or coinsurance from the covered member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:</p> <ol style="list-style-type: none"> 1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: <ul style="list-style-type: none"> • Breast cancer; • Cervical cancer; • Colorectal cancer; • High Blood Pressure; • Type 2 Diabetes Mellitus; • Cholesterol; • Child and Adult Obesity. 2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and 4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. <p>Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.</p>	<p>\$30 copay per office visit. Deductible waived. No coinsurance required for: Early intervention services, preventive services and immunizations (including the cervical cancer vaccination) pursuant to the schedule established by the Advisory Committee on Immunization Practices.</p> <p>Child health supervision services shall be provided up to age 13. Child health supervision services shall be exempt from a deductible or dollar limit provision. Copayments and coinsurance may be imposed for child health supervision services, but they shall not exceed the copayment or coinsurance payment, as applicable, to a physician visit.</p> <p>50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount for any other covered preventive care services not mandated by Colorado law.</p>

	IN-NETWORK	OUT-OF-NETWORK
<p>PREVENTIVE CARE (continued) b) Adults' services</p>	<p>Preventive Care Services shall meet requirements as determined by federal and state law. Many preventive care services are covered by this policy with no deductible, co-payments or coinsurance from the covered member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:</p> <ol style="list-style-type: none"> 1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: <ul style="list-style-type: none"> • Breast cancer; • Cervical cancer; • Colorectal cancer; • High Blood Pressure; • Type 2 Diabetes Mellitus; • Cholesterol; • Child and Adult Obesity. 2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; 3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and 4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration. <p>Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.</p>	<p>\$30 copayment per office visit Deductible waived. No coinsurance required for: Routine cytological screening (pap test), mammography benefit in accordance with Colorado law, colorectal cancer examination and related laboratory tests, cholesterol screening, immunizations against cervical cancer, influenza and pneumococcal vaccinations, alcohol misuse and tobacco use screening and behavioral counseling or cessation interventions, and prostate cancer screening. 50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount for any other covered preventive care services not mandated by Colorado law.</p> <p>Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.</p>
<p>10. MATERNITY a) Prenatal care</p> <p>b) Delivery & inpatient well baby care⁵</p>	<p>30% coinsurance after deductible.</p> <p>30% coinsurance after deductible.</p>	<p>50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.</p> <p>50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.</p>

	IN-NETWORK	OUT-OF-NETWORK
<p>11. PRESCRIPTION DRUGS⁶ Level of coverage and restrictions on prescriptions a) Outpatient care</p>	<p>Participating Retail Pharmacy: Tier 1 Prescription Drugs: ○ \$15 copayment for each prescription and/or refill for a maximum thirty (30) day supply.</p> <p>Tier 2 Prescription Drugs: After the \$7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied: ○ \$40 copayment for each prescription and/or refill for a maximum thirty (30) day supply.</p> <p>Tier 3 Prescription Drugs: After the \$7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied: ○ 50% coinsurance for each prescription and/or refill for a maximum thirty (30) day supply.</p> <p>Tier 3 Specialty Prescription Drugs*: After the \$7,500 Tier 2 and Tier 3 Prescription Drug Deductible has been satisfied: ○ 50% coinsurance, for each prescription and/or refill for a maximum thirty (30) day supply.</p> <p>*Specialty Pharmacy Drugs: Specialty drugs are high-cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty drugs may have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance.</p>	Not covered
<p>b) Prescription Mail Service</p>	<p>Mail Order: Tier 1 Prescription Drugs: ○ \$45 copayment for each prescription and/or refill up to a maximum ninety (90) day supply.</p> <p>Tier 2 Prescription Drugs: After a \$7,500 per member per calendar year Tier 2 and Tier 3 Prescription Drug Deductible is satisfied: ○ \$120 copayment for each prescription and/or refill up to a maximum ninety (90) day supply.</p> <p>Tier 3 Prescription Drugs: After a \$7,500 per member per calendar year Tier 2 and Tier 3 Prescription Drug Deductible is satisfied: ○ 50% coinsurance for each prescription and/or refill up to a maximum ninety (90) day supply.</p>	Not covered

	IN-NETWORK	OUT-OF-NETWORK
<p>PRESCRIPTION DRUGS⁶ Level of coverage and restrictions on prescriptions (continued)</p>	<p>Tier 2 and Tier 3 Prescription Drug Deductible Each member must meet a Tier 2 and Tier 3 Prescription Drug Deductible amount of \$7,500 each Year. This Deductible is separate from the annual Deductibles for medical benefits and does not accumulate towards satisfying the medical In-Network or Out-of-Network Provider Deductibles. This Tier 2 and Tier 3 Prescription Drug Deductible applies to Tier 2 and Tier 3 Prescription Drugs purchased at Participating Pharmacies and through the Mail Order Prescription Drug Program.</p> <p>Note:</p> <ul style="list-style-type: none"> • Copayments for the Tier 2 and Tier 3 deductible will not accumulate towards the Tier 3 Specialty Prescription Drug Coinsurance Maximum and will continue to be required even after the Tier 3 Specialty Prescription Drug Coinsurance Maximum has been reached. • The Tier 2 and Tier 3 Drug Deductible will not accumulate to satisfy the Tier 3 Specialty Prescription Drug Coinsurance Maximum. <p>Tier 3 Specialty Prescription Drug Coinsurance Maximum: There is a \$2,500 Tier 3 Out-of-Pocket Maximum for specialty prescription drugs per member per calendar year when purchased from preferred specialty pharmacies. You will not be required to pay more than \$2,500 per calendar year for specialty prescription drugs purchased from preferred specialty pharmacies. Once the \$2,500 Tier 3 Out-of-Pocket Maximum is met, no further copayments or coinsurance will be required for covered specialty prescriptions obtained from preferred specialty pharmacies, for the remainder of that calendar year.</p> <p>Note: Specialty drugs are only available through Anthem's specialty pharmacy benefit manager.</p> <p>Note:</p> <ul style="list-style-type: none"> • Copayments for Tier 1 and Tier 2 drugs will not accumulate towards the Tier 3 Prescription Drug Coinsurance Maximum, and will continue to be required even after the Tier 3 Prescription Drug Coinsurance Maximum has been reached. • The Tier 2 and 3 Prescription Drug Deductible does not accumulate to satisfy the Tier 3 Specialty Prescription Drug Coinsurance Maximum. • The Tier 3 Specialty Prescription Drug Coinsurance Maximum does not accumulate towards satisfying the medical In-Network and Out-of-Network Medical Out-of-Pocket Annual Maximum. <p>Prescription drug expenses do not apply towards the Out of Pocket maximum for medical benefits.</p> <p>Drugs obtained from pharmacies outside the United States will not be covered unless such drugs are prescribed in connection with Emergency.</p> <p>Non-Formulary Prescription Drugs: Charges for non-formulary prescription drugs will not be applied towards the Prescription Drug Deductible or the Tier 2 and Tier 3 Out-of-Pocket Maximum.</p> <ul style="list-style-type: none"> • 100% of the contracted amount if purchased from a participating pharmacy. • 100% of the cash price if purchased from a non-participating pharmacy. <p>Benefits for orally administered cancer chemotherapy will not be less favorable than the benefits for cancer chemotherapy that is administered intravenously or by injection. Oral chemotherapy must be found to be medically necessary by the treating physician for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in the terms of type, frequency, extent, site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider.</p>	
12. INPATIENT HOSPITAL	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
13. OUTPATIENT/AMBULATORY SURGERY	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
14. DIAGNOSTICS a) Laboratory & x-ray b) MRI, nuclear medicine, and other high-tech services	30% coinsurance after deductible. 30% coinsurance after deductible. Breast cancer screening with mammography in accordance with the "A" and "B" recommendations of the U.S. Preventive Services Task Force. Notwithstanding the "A" and "B" recommendations of the Task Force, an annual breast cancer screening with mammography shall be covered for all individuals with at least one risk factor.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount. 50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
15. EMERGENCY CARE^{7, 8}	30% coinsurance after deductible.	30% coinsurance after deductible.
16. AMBULANCE In the event of a medical emergency a) Ground b) Air Other than in a medical emergency a) Ground b) Air	30% coinsurance after deductible. 30% coinsurance after deductible. 30% coinsurance after deductible 30% coinsurance after deductible	30% coinsurance after deductible. 30% coinsurance after deductible. 50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount. 50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE⁹	Coverage is no less extensive than the coverage provided for any other physical illness.	Coverage is no less extensive than the coverage provided for any other physical illness.
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	30% coinsurance after deductible. 30% coinsurance after deductible.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount. 50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
20. ALCOHOL & SUBSTANCE ABUSE	30% coinsurance after deductible. Inpatient rehabilitation: Anthem will cover benefits up to a maximum of twenty (20) days, in- and out-of-network combined, per calendar year for inpatient rehabilitation for treatment of alcohol or drug abuse. Counseling: Anthem will pay benefits up to twenty (20) outpatient visits, in- and out-of-network combined, per calendar year for alcohol and drug abuse treatment.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
27. HOSPICE CARE a) Inpatient Care b) Outpatient care	30% coinsurance after deductible. 30% coinsurance after deductible. A benefit period is 91 days. Anthem will cover up to 91-days for routine home care services per benefit period up to three benefit periods, in- and out-of-network combined. Anthem will allow up to \$1,400 for Bereavement support services for the covered family members during the twelve-month period following the death of the member. Please see the Hospice section in your certificate for a description of covered services.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount. 50% coinsurance, plus all charges in excess of the maximum allowed amount.
28. SKILLED NURSING FACILITY CARE	30% coinsurance after deductible. Benefits are limited to one hundred (100) days per member per year, in- and out-of-network combined.	50% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
29. DENTAL CARE	Not covered	Not covered
30. VISION CARE	Not covered	Not covered
31. CHIROPRACTIC CARE	Covered under PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY (see line 21).	Covered under PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY (see line 21).
32. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Members who desire another professional opinion may obtain a second surgical opinion. For treatment by a physician or dentist of an Accidental Injury to the natural teeth, if the injury occurs while you are covered under the Agreement, and the services are received within six months of the injury.	

PART C: LIMITATIONS AND EXCLUSIONS

33. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.¹⁰	12 months for all pre-existing conditions unless the covered person is a HIPAA-eligible individual as defined under federal and state law or under age 19, in which case there are no pre-existing condition exclusions.
34. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No.
35. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	Members under the age of 19 will not be subject to benefit exclusions or limitations for a health condition that is considered to be pre-existing condition. For members age 19 and older, a pre-existing condition is an injury, sickness, or pregnancy for which a person incurred charges, received medical treatment, consulted a health-care professional, or took prescription drugs within 12 months immediately preceding the effective date of coverage.
36. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. List of exclusions is available immediately upon request from your carrier, agent, or plan sponsor (e.g., employer). Review them to see if a service or treatment you may need is excluded from the policy.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
37. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
38. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, the physician who schedules the procedure or hospital care is responsible for obtaining preauthorization.	Yes, the member is responsible for obtaining preauthorization unless the provider participates with Anthem Blue Cross and Blue Shield.
39. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, unless the provider participates with Anthem Blue Cross and Blue Shield.
40. What is the main customer service number?	(888) 231-5046	
41. Whom do I write/call if I have a complaint? Whom do I write if I want to file a grievance? ¹¹	Anthem Customer Service Department P.O. Box 5747, Denver, CO 80217-5747 (888) 231-5046 Anthem Quality Management 700 Broadway – MC 0532, Denver, CO 80273	
42. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance, ICARE Section 1560 Broadway, Suite 850, Denver, CO 80202	
43. To assist in filing a grievance, indicate the form number of this policy; whether it is individual, small group, or large group; and if it is a short-term policy.	Policy form # MCOCN636A, individual	
44. Does the plan have a binding arbitration clause?	Yes	

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

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

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

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

^{2c} "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA qualified policy and it may be an aggregated amount (e.g., "\$3000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "Non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid. **Note:** Family coverage is not provided under this policy.

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

⁴ Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically based mental illness.

⁵ Well baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. The hospital copayment applies to mother if complication of pregnancy and well-baby together: there are not separate copayments.

⁶ Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

⁷ "Emergency care" means all services delivered in an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition or life- or limb threatening emergency existed.

⁸ Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after-hours care, then urgent care copayments apply.

⁹ "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

¹⁰ Waiver of pre-existing condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

¹¹ Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

Anthem Blue Cross and Blue Shield & HMO Colorado Health Benefit Plan Description Form Disclosure Amendment

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

Pursuant to Colorado law (C.R.S. §10-16-107(7)(a), services or supplies for the treatment of Intractable Pain and/or Chronic Pain are not covered.

This coverage is renewable at your option, except for the following reasons:

- 1. Non-payment of the required premium;**
- 2. Fraud or intentional misrepresentation of material fact on the part of the plan sponsor;**
- 3. The commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations;**
- 4. The carrier elects to discontinue offering and non-renew all of its individual plans delivered or issued for delivery in Colorado.**

Cancer Screenings

At Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Colorado, Inc., we believe cancer screenings provide important preventive care that supports our mission: to improve the lives of the people we serve and the health of our communities. We cover cancer screenings as described below.

Pap Tests

Payment for an annual Pap test is based on the plan's laboratory services provisions, and payment for the related office visit is based on the plan's preventive care provisions..

Mammogram Screenings

All plans except our HMO and PPO Basic Health provide mammogram screening coverage for women in accordance with the "A" and "B" recommendations of the U.S. Preventive Services Task Force. Frequency guidelines can be found in your certificate. Payment for the mammogram screening benefit is based on the plan's provisions for X-ray services.

Prostate Cancer Screenings

All plans except our HMO and PPO Basic Health Plans provide prostate cancer screening coverage for men 40 years of age and older. Frequency guidelines can be found in your certificate. Payment for the prostate cancer screening benefit is based on the plan's provisions for X-ray services.

Colorectal Cancer Screenings

Several types of colorectal cancer screening methods exist. All plans provide coverage for colorectal cancer screenings, such as colonoscopies, sigmoidoscopies and fecal occult blood tests. Depending on the type of colorectal cancer screening received, payment for the benefit is based on the plan's provisions for laboratory services, preventive care office visit services, or other medical or surgical services. Our plans do not provide coverage for preventive colorectal cancer screenings involving invasive surgical procedures and DNA analysis.

The information above is only a summary of the benefits described. The certificate for each health plan includes important additional information about limitations, exclusions and covered benefits. The Health Benefit Plan Description Form for each health plan includes additional information about copayments, deductibles and coinsurance. If you have any questions, please call our customer service department at the phone number on the Health Benefit Plan Description Form.

SUMMARY OF THE LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION ACT AND NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS

Introduction

Residents of Colorado who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Life and Health Insurance Protection Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Colorado and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

IMPORTANT DISCLAIMER

The Life and Health Insurance Protection Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require residency in Colorado. You should not rely on coverage by the Life and Health Insurance Protection Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the association to induce you to purchase any kind of insurance policy.

Summary

The state law that provides for this safety-net coverage is called the Life and Health Insurance Protection Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association.

Coverage. Generally, individuals will be protected by the Life and Health Insurance Protection Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Certain parties to structured settlement annuity contracts may be entitled to coverage benefits as well based on defined circumstances.

This Information is Provided By:

Life & Health Insurance
Protection Association
P.O. Box 36009
Denver, CO 80236
(303) 292-5022

Colorado Division of Insurance
1560 Broadway
Suite 850
Denver, CO 80202
(303) 894-7499

Exclusions From Coverage. Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Colorado, except under certain very specific circumstances
- the insurer was not authorized or licensed to do business in Colorado at the time the policy or contract was issued;
- their policy was issued by a nonprofit hospital or health service corporation, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rate yields, crediting rate yields or other factors employed in calculating returns, including but not limited to indexes or other external references stated in the policy or contract, that exceed an average rate specified in the Association Act;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- any unallocated annuity;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- policies or contracts issued by an insurer which was insolvent or unable to fulfill its contractual obligations as of July 1, 1991, except for annuity contracts issued by a member insurer which was placed into liquidation between July 1, 1991, and August 31, 1991;
- policies or contracts covering persons who are not citizens of the United States;
- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

Limits On Amount Of Coverage. The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the Association will pay a maximum of:

- \$300,000 in net life insurance death benefits and no more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits - \$100,000 for coverages not defined as disability, basic hospital, medical and surgical, or major medical insurance, including any net cash surrender and net cash withdrawal values; \$300,000 for disability insurance; or \$500,000 for basic hospital, medical and surgical, or major medical insurance;
- \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or
- with respect to each payee of a structured settlement annuity, \$250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- \$300,000 for long term care benefits.

The Association shall not be liable to expend more than \$300,000 in the aggregate, with respect to any one life except that with respect to benefits for basic hospital, medical and surgical and major medical insurance, the aggregate liability of the Association shall not exceed \$500,000 with respect to any one individual

NOTE: For GF and NGF. As noted above in this disclaimer, this summary does not apply to HMO plans and ASO plans.