Anthem
Health. **Join In.**

Individual and Family Health Care Plans
for Colorado

Our plans fit your plans

Lumenos® HSA Plus

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Why do you need health care coverage?

These days, a single day in the hospital can cost thousands of dollars. The financial risk you take without health coverage just isn't worth it. Not only does health care coverage help you stay healthy, it also gives you added security, because you know you're protected against the high cost of unexpected medical bills.

Our plans fit the way you live.

In a world that's constantly changing, one thing's for certain: it's important to have health care coverage you can depend on – coverage designed to help fit your budget, and your way of life.

For over 70 years, Anthem has provided health care coverage and security to our Colorado neighbors. And now, we're pleased to offer these same individual health care plans with added benefits and features of the Patient Protection and Affordable Health Care Act.

You're in charge of your health and budget, and our Individual health care plans help keep it that way. We still offer a wide range of coverage options as unique as you are. And if you have any questions, we're here to help.

Sounds like a plan.

Experience you can rely on

Anthem is committed to helping simplify your life and improving your health. That's why we offer:

- **One of the largest provider networks in Colorado.** With nearly 7,500 doctors and over 75 hospitals throughout the state, chances are your doctor is one of ours.
- **A choice of plans to fit your budget and lifestyle.** No matter where you are in life, we've got a plan designed to fit your health coverage needs, as well as your budget.
- **Optional dental and term life insurance.** To enhance your health and your family's financial future, we also offer dental and term life coverage and make it easy to enroll.
- **Coverage that travels with you.** No matter where life takes you, your health coverage goes with you. And the BlueCard® program makes it easy to access providers throughout the country.

Some definitions so we're all on the same page

Network Discounts: With Anthem, you have access to one of the largest provider networks in the state. These network (or participating) providers have agreed to accept lower costs for their covered services to Anthem members — similar to volume discounts. These negotiated costs help reduce the overall cost of covered medical services, including your share of those costs.

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With nearly 7,500 doctors and specialists and over 75 hospitals, chances are your provider already participates. Just visit a network provider to take advantage of the savings.

With our PPO plans, you can always choose to receive services outside the network, but your share of the cost will be greater.*

Cost–Sharing: The costs of medical care today can be staggering. Health care coverage from Anthem can help protect you against these high costs. With most health care coverage, you pay a monthly premium, then you share some of the cost of covered medical care with the company that provides your health care coverage. The level of cost-sharing you choose directly impacts your premium amount. The more you are willing to share in the cost, the lower your premium. With Anthem, you can choose your level of protection and the level of cost-sharing that works best for your health care needs and budget.

Deductible is the amount you have to pay each calendar year for covered services before your health care plan starts paying. For some services, the plan will even begin to pay before the deductible is met. Usually, the higher a plan's deductible, the lower the premium. In some cases, you may also have a separate deductible for certain services such as prescription drugs.

Coinsurance is the percentage of the cost of covered services that you will be responsible for, after your annual deductible is met. With some plans, you have a choice of coinsurance levels. Much like your deductible, selecting a higher coinsurance typically lowers your monthly premium because it increases your share of the cost.

Copayment is a specific dollar amount you have to pay for certain covered services.

Out-Of-Pocket Maximum is the most that you would pay in a calendar year for deductible and coinsurance for in-network covered services. Once you reach this maximum, the plan pays at 100% for most services for the rest of the calendar year.

Prescription Drugs are medications that must be authorized for use by your doctor. Anthem offers varying levels of prescription drug coverage. Depending on the plan, you may have coverage for generic drugs or generic and brand name drugs.

Generic Drugs are prescription drugs that typically have been in use for some time and can be manufactured and distributed by numerous companies, so their cost is usually much lower. Generic drugs must, by law, contain the same active ingredients as their brand name equivalent and have the same clinical benefit.

Brand Name Drugs are prescription drugs that are manufactured and marketed under a registered name. They are usually patented and may be exclusively offered by certain manufacturers.

Specialty Drugs are typically high cost, scientifically engineered drugs used to treat complex, chronic conditions. They require special handling and usually must be shipped directly to the user.

Formulary is a list of prescription drugs our health care plans cover. They include generic, brand name, and specialty drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans.

Health Savings Account (HSA) is a special bank account that can be set up by a member enrolled in a qualified HSA-compatible high-deductible health plan if they choose. Contributions to this account can be made with certain tax advantages and funds from the account can be used for qualified health care expenses. See the insert from our preferred banking partner for more details and consult your tax advisor.

***Unlike participating providers, non-participating providers may send you a bill and collect for the amount of the provider's charge that exceeds the maximum allowed amount. Customer service is available to assist you in determining your plan's maximum allowed amount for a particular service from a non-participating provider.**

Lumenos® HSA Plus Is this the right plan for you?

Lumenos HSA Plus health plans were designed to give you more control over your health care costs. They help you focus on getting healthy and staying that way.

Lumenos HSA Plus Plan Highlights

This plan offers traditional health care benefits that can be paired with a Health Savings Account (HSA) for more flexibility and potential tax advantages. Simple plan designs make using them that much easier.

Features:

- Preventive care benefits help focus on keeping you healthy.
- PPO health plan coverage with a large array of benefits after you pay your deductible.
- Network services covered 100% after you meet your deductible.
- Coverage compatible with an HSA that is yours to fund and keep if you choose. Use the HSA for qualified medical expenses or as a savings vehicle. Just contact your tax advisor for possible advantages.
- Special programs for Smoking Cessation and Weight Management.
- Access to our 24-hour Nurse Line.
- Online tools for a personalized Health Assessment, prescription drug cost comparison, and other tools to give you more control.

You should know:

- Your Lumenos HSA Plus plan has a policy-level deductible and out-of-pocket maximum. Once any combination of covered members on the policy meet these amounts, the plan pays 100% of covered expenses. It's that simple.
- While Lumenos HSA Plus is compatible with a Health Savings Account, your health care plan works with or without it. You may set up the HSA now, later, or not at all. It's your choice.

Prescription Drug Coverage

Lumenos HSA Plus not only puts you in charge of your health care dollars, it can help you use those dollars for generic and brand name prescription drugs in the way that best suits you.

Once your deductible is met, covered prescription drugs are covered at 100%. And even while you are meeting your deductible, you benefit from lower negotiated rates on prescription drugs at network pharmacies nationwide. There's no need to have a different deductible or copayment for prescriptions; it all works as one.

And since you decide how to spend it, your Health Savings Account dollars can be used to pay for prescription drugs while you are meeting your deductible.

How to Customize your Lumenos HSA Plus Plan

Choose your deductible: You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you. Remember, any covered member can contribute to some or all of the policy deductible and out-of-pocket maximum, whether the policy covers one member or a whole houseful.

Use your Health Savings Account the way you want: Your HSA, if you choose to open one, is funded by you. So, it is yours to use for qualified health care expenses covered by the plan, or those not covered at all, like contact lenses. Your HSA is also yours to keep if you ever leave the plan; you won't lose those dollars if they're not used. In fact, the carryover from year to year can help you save for future financial needs. See the enclosed insert from our preferred banking partner for more information.

Other Optional Coverage: You can add more protection for you and your family by purchasing optional dental or life insurance. See the information at the back of this brochure.

Benefits

Lumenos® HSA Plus

Calendar Year Deductible

Your Choices

		SINGLE POLICY COVERAGE:			FAMILY POLICY COVERAGE:		FAMILY POLICY COVERAGE:	
Individual	NETWORK:	$3,000	$4,500	$5,950	N/A	N/A	N/A	N/A
	NON-NETWORK:	$3,000	$4,500	$5,950	N/A	N/A	N/A	N/A
Family	NETWORK:	N/A	N/A	N/A	$3,500	$5,500	$7,500	$11,900
	NON-NETWORK:	N/A	N/A	N/A	$3,500	$5,500	$7,500	$11,900
Network Coinsurance Options		0%	0%	0%	0%	0%	0%	0%

Calendar Year Out-of-Pocket Maximum

Add Your Chosen Deductible to the Amount Below

		SINGLE POLICY COVERAGE:			FAMILY POLICY COVERAGE:		FAMILY POLICY COVERAGE:	
Individual	NETWORK:	$0	$0	$0	N/A	N/A	N/A	N/A
	NON-NETWORK:	$3,000	$4,500	$5,950	N/A	N/A	N/A	N/A
Family	NETWORK:	N/A	N/A	N/A	$0	$0	$0	$0
	NON-NETWORK:	N/A	N/A	N/A	$3,500	$5,500	$7,500	$11,900

How family deductibles and family out-of-pocket maximums work	Not applicable for Single policy coverage	Either one or more members must meet the family deductible. The family out-of-pocket maximum can be met by either one or more members. Once the maximum is met, no additional coinsurance will be required for the family for remainder of the calendar year.	Once one family member reaches half the family deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined. Once the maximum is met, no additional coinsurance will be required for the family for remainder of the calendar year.

Plan Lifetime Maximum	Unlimited

Covered Services

Your Share of Costs (after deductible, unless waived)

Doctors' Office Visits	**NETWORK:** 0% Coinsurance **NON-NETWORK:** 40% Coinsurance
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK:** 0% Coinsurance **NON-NETWORK:** 40% Coinsurance
Inpatient Services (overnight hospital/facility stays)	**NETWORK:** 0% Coinsurance **NON-NETWORK:** 40% Coinsurance
Outpatient Services (without overnight hospital/facility stays)	**NETWORK:** 0% Coinsurance **NON-NETWORK:** 40% Coinsurance
Emergency Room Services	**NETWORK:** 0% Coinsurance **NON-NETWORK:** 0% Coinsurance
Preventive Care Services	Covers all nationally recommended preventive care services, including well-child care, immunizations, PSA screenings, Pap tests, mammograms, and more. **NETWORK:** 0% Coinsurance, not subject to deductible **NON-NETWORK:** · **Adults:** Routine mammogram, Pap, PSA and Colorectal screenings, immunizations (children under age 13) covered at no cost to member, deductible waived · **All other covered Adult Preventive Services:** $30 Copay, deductible waived
Maternity	**NETWORK:** 0% Coinsurance **NON-NETWORK:** 40% Coinsurance
Optional Coverage (at additional cost)	Dental, Life

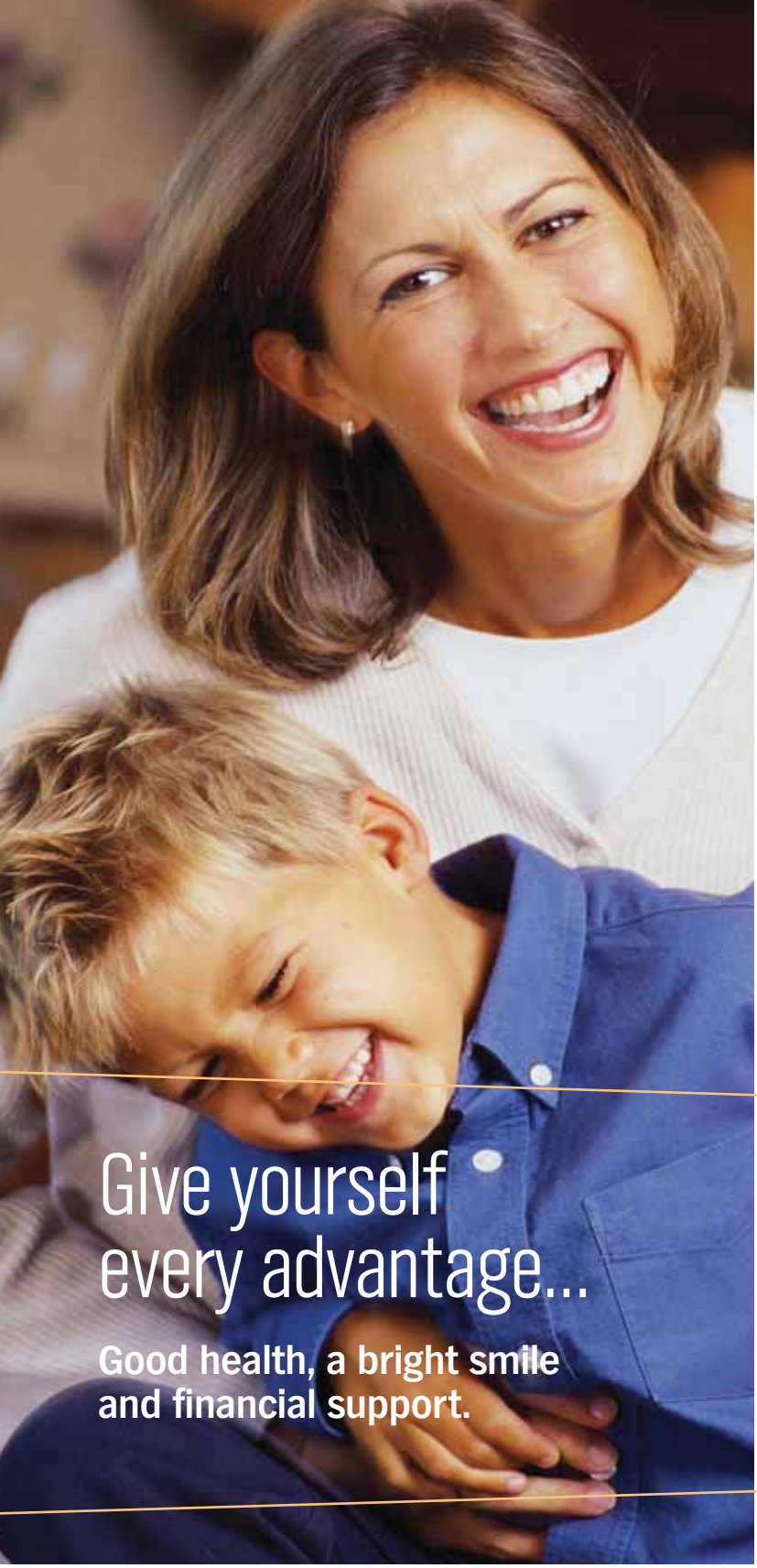
Prescription Drug Coverage

Lumenos HSA Plus

Retail Drugs (and Mail Order Drugs when available)	**NETWORK:** 0% Coinsurance **NON-NETWORK:** 40% Coinsurance
Optional Drug Coverage (when available)	Not Available
Other Covered Benefits include but are not limited to:	Ambulance, Chiropractic Services, Home Health Care, Mental Health, Physical/Occupational Therapy, Urgent Care

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 Contract/Certificate of Coverage. In the event of a conflict between the Contract/Certificate of Coverage and this Benefit Guide, the terms of the Contract/Certificate of Coverage will prevail.

NOTES:
- Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate toward each other.
- Lumenos HSA plans feature a combined medical/pharmacy deductible so your payments for prescription drugs also apply toward your plan deductible and out-of-pocket maximum.



Dental Coverage

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

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 you to go to *any* dentist, you may save the most money when you choose one of the dentists in our PPO provider network. Even better, when you visit a network dentist, there is no deductible or member coinsurance for covered diagnostic or preventive services. For basic and major services, the calendar-year deductible is $50 per person (up to three deductibles per family) and must be satisfied before we will pay any benefits.

Diagnostic and Preventive Care

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

Diagnostic and Preventive Care		
Procedure	**Plan Pays**	
	Network	**Non-Network**
Periodic oral exams, routine cleanings and X-rays *(cleanings limited to two per member per year)*	**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, root canals, crowns, dentures	**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.

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-of-network providers will bill members for amounts over what the member's plan pays, up to their usual charge.

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.

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.

If you're accepted for coverage on one of our health care plans, you'll 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.

Term life monthly rates

Age	$15,000 Benefit	$25,000 Benefit	$50,000 Benefit	$75,000 Benefit	$100,000 Benefit
1-18	$1.50	$2.50	N/A	N/A	N/A
19-29	$2.80	$4.65	$9.30	$11.25	$13.00
30-39	$3.25	$5.40	$10.80	$13.50	$16.00
40-49	$7.50	$12.50	$25.00	$33.75	$42.00
50-59	$20.90	$34.80	$69.60	$97.50	$125.00
60-64	$29.40	$49.00	$98.00	$142.50	$185.00

Up to $100,000 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.

Additional information

Save time with automatic premium payments

Hate writing checks? After your initial payment, our Electronic Fund Transfer (EFT) program will automatically withdraw funds from your bank account each month to pay for your health plan premium. You'll not only save on postage, you won't have to worry about a lapse in coverage because you forgot to mail in your payment. To sign up, just fill out the billing section of the enrollment application.

"No Obligation" review period.

After you enroll in a plan offered by Anthem, you will receive a Certificate that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You will have 30 full days to examine your plan's features. During that time, if you are not fully satisfied, you may decline coverage by returning your Certificate along with a letter notifying us that you wish to discontinue coverage. You'll receive a full refund of any premium, less any claims we've paid on your behalf. Certificates are available for you to examine prior to enrolling. Ask your agent or Anthem.

Anthem
Health. **Join In.**

Individual and Family Health Care Plans
for **Colorado**

Individual health coverage. Your plans. Your choices.

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 brochure from your computer, it should be at the end. If you did not receive a copy of the Coverage Details, 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!

Benefits effective January 1, 2011

Stay focused on your fitness.

Anthem

Let ACS | Mellon handle the finances.

Setting up a Health Savings Account

The Lumenos® HSA plan is a nice way to save on premiums. But that's just the tip of the savings iceberg. To realize your plan's full financial power, consider opening a health savings account to go with your Lumenos plan. The portability and tax savings of an HSA account can add up fast.

We've joined with Affiliated Computer Services (ACS) and The Bank of New York Mellon (BNY Mellon) to integrate their HSA accounts with our Lumenos HSA plans. Setting up your account with BNY Mellon is easy. Plus, it comes with built-in advantages and conveniences:

- A single customer service contact for the health plan and your HSA
- A single online health site to access your plan benefit information and account details
- Several payment and deposit options, including special checks and automatic fund transfers
- Competitive interest rates and investment opportunities for the funds in your account

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

YOU'RE ONLY ONE CHECKMARK AWAY

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

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A closer look

HSA Welcome Kit

If you make the selection on your application form, your Health Savings Account will automatically be set up once you're approved for the Lumenos HSA plan, and you'll soon receive an HSA Welcome Kit. In it, you'll find all of the banking documentation and instructions for using your account. A separate application for your account is only required if you choose a financial institution other than BNY Mellon.

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

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

Interest and investments

You'll earn interest on your HSA funds and have the chance to invest your funds as long as you keep a minimum $2,000 HSA balance. Investment options include a number of mutual families. Once you're ready to invest, just call the ACS | Mellon HSA Solution Contact Center at 866-686-4798 Monday through Friday from 8 a.m. to 8 p.m. (Eastern Time) for a prospectus with more details.

Debit cards and checkbooks

Use your MasterCard® debit card or your HSA checkbook (provided by BNY Mellon) to pay your health care provider or pharmacy directly for eligible medical expenses, or to get cash from your account.

Deposits to your account

To contribute to your HSA, simply send a check and deposit slip to the address printed on your HSA checkbook. Or you can set up an electronic funds transfer between your bank and BNY Mellon for regular account contributions.

Account activity statements

Each month, you'll receive a statement from BNY Mellon that shows all of your account activity. For an additional fee of $0.75 per month, you can receive a paper statement. Please go to Anthem.com or call your dedicated Customer Service to learn how to elect this option. You'll also receive IRS 1099 and IRS 5498 forms from BNY Mellon near tax time to help with tax preparation.

ACS | Mellon HSA fee and rate schedule

A Deposit Agreement and a Disclosures and Fee Sheet will be in your HSA Welcome Kit. Please refer to those documents for the complete terms and conditions related to your account.

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

Administrative fees	
One time account set-up	$15
Banking fees	
Monthly account fee	$2.95
Debit card transactions	no charge
Check writing	no charge
ATM transactions	$1
Card replacement	$5
Check reorder	$10
Non-sufficient funds	$25
Stop check service	$25
Duplicate check	$5
Periodic paper statement	$0.75

ACS | BNY Mellon is an independent corporate entity that provides banking administration on behalf of Anthem Blue Cross and Blue Shield.

Colorado Coverage Details

Things you need to know before you buy...

Anthem Health. **Join In.**

CoreShare Plus,[SM] SmartSense Plus,® Lumenos® HSA Plus, Premier, ClearProtection

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

To Enroll, You And Your Dependents Must Be:

- At least 19 years of age (not to exceed 64 3/4 years of age) to be eligible as the main subscriber. Child dependents under the age of 19 must apply and be enrolled with at least one parent or legal guardian (age 19 years or older)
- A permanent legal resident of Colorado

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 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 qualify for the plan(s) listed in this brochure, or
- You may be offered an alternate plan

If you have a significant medical condition and don't qualify for the plan you've chosen from this brochure or if you have discontinued group coverage, please contact your Anthem representative for information regarding other Individual coverage options.

Waiting Periods

For applicants age nineteen (19) and older there is a 12-month waiting period for coverage of any health condition, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received within 12 months preceding the coverage effective date. If you apply for coverage within 90 days of terminating your membership with another 'creditable' health care benefits plan, you may use your prior coverage for credit toward the 12-month waiting period. Anthem will credit the time you were enrolled in the previous plan. The pre-existing condition limitation does not apply to applicants under age nineteen (19). Consult with your Anthem agent or representative if you have a question about the underwriting process.

Guaranteed Renewability Of All Individual Health Policies

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

- Non-payment of premium
- Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by the insured
- Anthem elects to discontinue offering all Individual policies
- The state insurance commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders
- 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 Plan Description Form

Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate 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 also must 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 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 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, which 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 www.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 Management 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 timeframes 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, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite.

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 healthcare professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

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 Plan Description Form and Certificate.

CoreShare Plus, SmartSense Plus, Premier and ClearProtection Plans Do Not Cover:

- Acupuncture
- 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, condition of employment, for licensing, school, church or camp or 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 nineteen 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

Lumenos HSA Plus Does Not Cover:

- All services related to artificial conception, except as provided in the member's Certificate
- Auto accident injuries, except as provided in the member's Certificate
- Breast reduction surgery or services related to breast reduction surgery, unless the surgery is performed as a result of breast cancer
- Services received before the member's plan effective date
- Services received after the member's coverage ends, except as provided in the member's Certificate
- Complications resulting from non-covered services and supplies
- Convalescent care from a period of illness, injury or surgery unless normally received for a specific condition, as determined by Anthem Blue Cross and Blue Shield's medical policy
- Cosmetic services
- Court-ordered services, unless those services would otherwise be covered under the member's Certificate
- Custodial Care
- Dental services, except as provided in the member's Certificate
- Experimental or investigational services
- Genetic testing/counseling
- Government operated facility, including veterans administration facility
- Hair loss, even if there is a physician prescription and a medical reason for the hair loss
- Hypnosis, whether for medical or anesthesia purposes
- Services or supplies for illness or injuries resulting from the member's conduct that may be deemed a crime or other violation of law
- Intractable pain or chronic pain
- Learning deficiency and/or behavioral problem therapies, except as provided in the member's Certificate
- Maintenance therapy
- Charges for the member's failure to keep scheduled appointments
- Neuropsychiatric testing, unless allowed by Anthem's medical policy
- Over-the-counter products
- Services or supplies that are not medically necessary
- For ages 19 and older, services related to a pre-existing condition as defined in the member's Certificate
- Private duty nursing
- Private room expenses, except as provided in the member's Certificate
- Professional or courtesy discounts the member receives from a provider for services and supplies
- Radiology services such as Ultrafast CT scan and peripheral bone density testing, except as provided in the member's Certificate
- Charges for the preparation of medical reports, itemized bills or charges for duplication of medical records from a provider when requested by the member
- Services for self-inflicted injuries, except where the law prohibits such an exclusion
- Services the member wouldn't have to pay for without insurance (free services)
- Sex change operations
- Services related to alcohol or drug abuse except as provided in the member's Certificate
- Travel expenses, except as provided in the member's Certificate
- Vision care
- Services or supplies necessary to treat disease or injury resulting from war, civil war, insurrection, rebellion or revolution
- Services primarily for weight reduction, except medically necessary treatment for morbid obesity
- Work-related accidents or illnesses covered by worker's compensation

SmartSense Plus, ClearProtection, Premier, and Lumenos HSA Plus plans do not cover autism.

Dental Benefits Which Are Not Covered By Anthem Dental

The following information will help you understand what your dental 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 Dental Plan Certificate.

Limitations

This is a partial list of plan limitations. Please see the Individual Dental Plan Contract for a complete list.

- Oral Evaluations: Limited to two per calendar year
- Routine Cleaning or Periodontal Cleaning: Limited to two treatments per calendar year
- Fluoride: Fluoride treatment limited to two per calendar year for children up to age 19

- X-rays: Limited to one set of full-mouth X-rays or its equivalent in a five-year period. Periapical X-rays are limited to four films per year
- Bitewing X-rays: Limited to one set of up to four films once per calendar year
- Sealants, for unrestored permanent 1st and 2nd molars. Limited to one application per tooth and one replacement per tooth if replacement is performed at least 36 months after initial application. Covered only for dependent children up to the age of 16
- Space Maintainers. Limited to once per quadrant per lifetime for children up to the age of 16. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes initial prosthesis only and all adjustment within six months of placement
- Restorations: Limited to once per surface per tooth every 24 months
- Periodontal Scaling: Limited to once per quadrant every 24 months
- Periodontal Surgery: Limited to one time per quadrant in a 36-month period
- Root Canal Therapy: Limited to one treatment per tooth for initial treatment and one retreatment per tooth per lifetime — for permanent teeth only
- Stainless Steel Crowns: Limited to baby teeth only. Once per tooth in any five years
- Crowns: Limited to once per tooth in any seven years
- Removable, Partial and Complete Dentures: Limited to once in seven years. Benefits are payable for either complete or immediate dentures, but not both
- General Anesthesia: Covered only when used in conjunction with covered oral surgical procedures

Exclusions

This is a partial listing of plan exclusions. Please see the Individual Dental Plan Contract for a complete list.

- Prescribed drugs, pre-medication or analgesia including charges for nitrous oxide or any similar local anesthetic when not included as part of a covered procedure
- Occlusal guards
- Bleaching of non-vital discolored teeth
- Crown buildups on the same tooth as an amalgam or composite restoration that was done within the same calendar year
- Procedures to alter, restore or maintain occlusion, change vertical dimension, and replace or stabilize tooth structure lost by attrition, abrasion, erosion or bruxism
- Harmful habit appliances
- Services related to diagnosis or treatment related to the temporomandibular joint (TMJ)
- Dental implants and all adjunctive services performed in conjunction with the placement or removal of implants including but not limited to surgery, cleanings, maintenance and prosthetics placed on implants
- Infection control procedures, if billed separately
- Precision attachments
- Prefabricated resin crown or stainless steel crown with resin window
- Pulpotomy on permanent teeth
- Replacement of a prosthodontic appliance (fixed or removable) more often than once in any seven-year period, whether under this Contract or under any prior dental coverage
- Root canal therapy on baby teeth
- Sealants on restored teeth (occlusal surface)
- Temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.)
- Services or supplies not specifically listed in the covered services section of the Individual Dental Plan Contract

This is not a contract of insurance and only your Application, Certificate of Coverage and your Health Plan Description Form constitute legally binding documents. Please refer to the applicable Certificate/Health Plan Description Form which sets forth, in more detail, the benefits, limitations and exclusions. If there are any conflicts between the terms of the Certificate/Health Plan Description Form and the information outlined above, the terms of the Certificate/Health 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 are also providing you with the Brochure, Health Plan Description Form and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem agent to request them.

The Certificate/Health Plan Description Form is also available for you to examine before enrolling. Ask your Anthem agent or Anthem.

Anthem
Health. Join In.

Colorado Health Benefit Plan Description Form
Anthem Blue Cross and Blue Shield
Lumenos Plus Health Savings Account (HSA–Compatible) Plans for Individuals
Effective January 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] (Applicable only to specified covered services. Separate deductibles for In and Out-of-Network; includes prescription drug expenses)	**Individual** $3,000 $4,500 $5,950 per individual	**Family** Family coverage not provided.	**Individual** $3,000 $4,500 $5,950 per individual	**Family** Family coverage not provided.
	After the individual deductible is satisfied, no further deductible is required for the remainder of that calendar year.		After the individual deductible is satisfied, no further deductible is required for the remainder of that calendar year. For non-participating providers, the allowable charge is the maximum benefit allowance. However, even if the deductible has been satisfied, the member will still be responsible for charges from the non-participating provider that are in excess of the maximum allowed amount or where specifically noted in the Certificate or the *Health Benefit Plan Description Form.* Charges in excess of the maximum benefit allowance will not be applied toward the deductible.	

	IN-NETWORK		OUT-OF-NETWORK	
4a. ANNUAL DEDUCTIBLE[2a] (Applicable only to specified covered services. Separate deductibles for In and Out-of-Network; includes prescription drug expenses)	**Individual** Single coverage not provided.	**Family** $3,500 $5,500	**Individual** Single coverage not provided.	**Family** $3,500 $5,500
	Aggregate Family Deductible Under a family membership (two (2) or more members enrolled), no individual deductible applies and the family deductible must be met before Anthem provides benefits. The family deductible amount is met as follows: When one family member has satisfied the family deductible, that family member and all other family members are eligible for benefits. When no family member meets the family deductible, but the family members collectively meet the entire family deductible, then all family members will be eligible for benefits for the remainder of that calendar year. After the family deductible is satisfied, no further deductible is required for the remainder of that calendar year.		**Aggregate Family Deductible** Under a family membership (two (2) or more members enrolled), no individual deductible applies and the family deductible must be met before Anthem provides benefits. The family deductible amount is met as follows: When one family member has satisfied the family deductible, that family member and all other family members are eligible for benefits. When no family member meets the family deductible, but the family members collectively meet the entire family deductible, then all family members will be eligible for benefits for the remainder of that calendar year. After the family deductible is satisfied, no further deductible is required for the remainder of that calendar year. For non-participating providers, the allowable charge is the maximum allowed amount. However, even if the deductible has been satisfied, the member will still be responsible for charges from the non-participating provider that are in excess of the maximum allowed amount or where specifically noted in the Certificate or the *Health Benefit Plan Description Form*. Charges in excess of the maximum allowed amount will not be applied toward the deductible.	

	IN-NETWORK		OUT-OF-NETWORK	
4a. ANNUAL DEDUCTIBLE[2a] (Applicable only to specified covered services. Separate deductibles for In and Out-of-Network; includes prescription drug expenses)	**Individual** Single coverage not provided.	**Family** $7,500 $11,900	**Individual** Single coverage not provided.	**Family** $7,500 $11,900
	Embedded Family Deductible Once the total of allowable charges applying to the deductible for two (2) or more members equal the family deductible, no further deductible will be required for all enrolled members for the remainder of that calendar year. However, no one member can contribute more than half of the family deductible amount to satisfy the family deductible. If an individual family member has satisfied one half of the Embedded Family Deductible, that individual family member only has then satisfied the Embedded Family Deductible for the current plan year with respect to any future claims by that family member. However, until 100% of the Embedded Family Deductible amount has been satisfied, it will continue to apply to all other family members. After the family deductible is satisfied, no further deductible is required for the remainder of that calendar year.		**Embedded Family Deductible** Once the total of allowable charges applying to the deductible for two (2) or more members equal the family deductible, no further deductible will be required for all enrolled members for the remainder of that calendar year. However, no one member can contribute more than half of the family deductible amount to satisfy the family deductible. If an individual family member has satisfied one half of the Embedded Family Deductible, that individual family member only has then satisfied the Embedded Family Deductible for the current plan year with respect to any future claims by that family member. However, until 100% of the Embedded Family Deductible amount has been satisfied, it will continue to apply to all other family members. After the family deductible is satisfied, no further deductible is required for the remainder of that calendar year. For non-participating providers, the allowable charge is the maximum allowed amount. However, even if the deductible has been satisfied, the member will still be responsible for charges from the non-participating provider that are in excess of the maximum allowed amount or where specifically noted in the Certificate or the *Health Benefit Plan Description Form*. Charges in excess of the maximum allowed amount will not be applied toward the deductible.	

	IN-NETWORK		OUT-OF-NETWORK	
5. OUT-OF-POCKET ANNUAL MAXIMUM (Separate for In and Out-of-Network; includes prescription drug expenses)	**Individual** $3,000 $4,500 $5,950 per individual, includes deductible and coinsurance.	**Family** Family coverage not provided	**Individual** $6,000 $9,000 $11,900 per individual, includes deductible and coinsurance.	**Family** Family coverage not provided
			A member will always be responsible for the difference between billed charges and the maximum allowed amount for non-participating providers, even after reaching the Out of Pocket Annual Maximum for Out-of-Network services. Charges in excess of the maximum allowed amount or where specifically noted in the certificate or *Health Benefit Plan Description Form* do not count towards satisfying the Out of Pocket Annual Maximum.	
c) Is the deductible included in the out-of-pocket maximum?	Yes		Yes	

	IN-NETWORK		OUT-OF-NETWORK	
5. OUT-OF-POCKET ANNUAL MAXIMUM (Separate for In and Out-of-Network; includes prescription drug expenses)	**Individual** Single coverage not provided.	**Family** $3,500 $5,500 per individual or family, includes deductible and coinsurance	**Individual** Single coverage not provided.	**Family** $7,500 $11,900 per individual or family, includes deductible and coinsurance
	Aggregate Family Out-of-Pocket Maximum Under a family membership, when one family member has satisfied the family out of pocket annual maximum, that family member and all other family members have satisfied the out of pocket annual maximum for that calendar year. When no family member meets the family out of pocket annual maximum on their own, but the family members collectively meet the entire family out of pocket annual maximum, then all family members will have satisfied the out of pocket annual maximum. The individual out of pocket maximum does not apply under a family membership.		**Aggregate Family Out-of-Pocket Maximum** Under a family membership, when one family member has satisfied the family out-of-pocket annual maximum, that family member and all other family members have satisfied the out-of-pocket annual maximum for that calendar year. When no family member meets the family out-of-pocket annual maximum on their own, but the family members collectively meet the entire family out-of-pocket annual maximum, then all family members will have satisfied the out-of-pocket annual maximum and all family members will be eligible for benefits for the remainder of that year. A member will always be responsible for the difference between billed charges and the maximum allowed amount for non-participating providers, even after reaching the Out of Pocket Annual Maximum for Out-of-Network services. Charges in excess of the maximum allowed amount or where specifically noted in the certificate or *Health Benefit Plan Description Form* do not count towards satisfying the Out of Pocket Annual Maximum. Note: The individual out-of-pocket maximum does not apply under a family membership.	

	IN-NETWORK		OUT-OF-NETWORK	
5. OUT-OF-POCKET ANNUAL MAXIMUM (Separate for In and Out-of-Network; includes prescription drug expenses)	**Individual** Single coverage not provided.	**Family** $7,500 $11,900	**Individual** Single coverage not provided.	**Family** $15,000 $23,800
	Embedded Family Out-of-Pocket Maximum Once the total of allowable charges for two (2) or more members equal the Family Out of Pocket Annual Maximum, no family member will be required to pay deductible or coinsurance amounts, except as otherwise required by this Certificate or the *Health Benefit Plan Description Form* for the remainder of that calendar year. However, no one person can contribute more than half of the Family Out-of-Pocket Annual Maximum to satisfy the Family Out-of-Pocket Annual Maximum. If an individual family member has satisfied one half of the Family Out-of-Pocket Annual Maximum, that individual family member only has then satisfied the Out-of-Pocket Annual Maximum for the current plan year with respect to any future claims by that family member. However, until 100% of the Family Out-of-Pocket Annual Maximum amount has been satisfied, it will continue to apply to all other family members.		**Embedded Family Out-of-Pocket Maximum** Once the total of allowable charges for two (2) or more members equal the Family Out of Pocket Annual Maximum, no family member will be required to pay deductible or coinsurance amounts for the remainder of that calendar year except as otherwise required by the Certificate or this *Health Benefit Plan Description Form*. No one person can contribute more than half of the Family Out-of-Pocket Annual Maximum amount to satisfy the Family Out-of-Pocket Annual Maximum. If an individual family member has satisfied one half of the Family Out-of-Pocket Annual Maximum, that individual family member only has then satisfied the Out-of-Pocket Annual Maximum for the current plan year with respect to any future claims by that family member. However, until 100% of the Family Out-of-Pocket Annual Maximum amount has been satisfied, it will continue to apply to all other family members. A member will always be responsible for the difference between billed charges and the maximum allowed amount for non-participating providers, even after reaching the Out of Pocket Annual Maximum for Out-of-Network services. Charges in excess of the maximum allowed amount or those charges specifically noted in the certificate or Health Benefit Plan Description Form do not count towards satisfying the Out of Pocket Annual 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.			

	IN-NETWORK	OUT-OF-NETWORK
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.
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**	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) Specialists	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
9. PREVENTIVE CARE **a) Children's services** Professional services are services provided during a physician office-based visit, including, but not limited to laboratory, X-ray, radiology and pathology services. Please see the Professional Services section of the certificate for a full description of covered professional services.	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: 1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: • 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.	$30 copayment 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. 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. Other covered preventive care services not mandated by Colorado law: 40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
b) Adults' services Professional services are services provided during a physician office-based visit, including, but not limited to laboratory, X-ray, radiology and pathology services. Please see the Professional Services section of the certificate for a full description of covered professional services.	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: 1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for: • 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.	$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. Other preventive care services not mandated by Colorado law: 40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Please see the Preventive Care Services section in your certificate for a full description of covered preventive care services.	
10. MATERNITY **a) Prenatal care**	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) Delivery & inpatient well baby care[5]	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
11. PRESCRIPTION DRUGS[6] **Level of coverage and restrictions on prescriptions** **a) Outpatient care**	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) Prescription Mail Service	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.

	IN-NETWORK	OUT-OF-NETWORK
	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.	
12. INPATIENT HOSPITAL	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
13. OUTPATIENT/AMBULATORY SURGERY	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
14. DIAGNOSTICS **a) Laboratory & x-ray**	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) MRI, nuclear medicine, and other high-tech services	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	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.	
15. EMERGENCY CARE[7, 8]	No coinsurance after deductible.	No coinsurance after deductible.
16. AMBULANCE **a) Ground** **b) Air**	No coinsurance after deductible. No coinsurance after deductible.	No coinsurance after deductible. No coinsurance after deductible.
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE[9]	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**	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Inpatient care islimited to 45 full or 90 partial days per member in each benefit year in- and out-of-network combined.	
b) Outpatient care	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Outpatient care is limited to 20 visits per member in each benefit year in- and out-of-network combined.	

	IN-NETWORK	OUT-OF-NETWORK
20. ALCOHOL & SUBSTANCE ABUSE	Not covered, except for benefits provided for Alcohol misuse screening, behavioral counseling interventions, tobacco use screening of adults and tobacco cessation interventions by outpatient primary care providers.	Not covered, except for benefits provided for Alcohol misuse screening, behavioral counseling interventions, tobacco use screening of adults and tobacco cessation interventions by outpatient primary care providers.
21. PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY **a) Inpatient**	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Covered for inpatient rehabilitation therapy for up to 30 days per member in each benefit year in- and out-of-network combined.	
b) Outpatient	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Speech therapy is limited to 60 visits per member in each benefit year in- and out-of-network combined, except for children to age 6.	
22. DURABLE MEDICAL EQUIPMENT	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	For prosthetic devices (arms and legs), benefits are at least equal to those benefits provided under federal law for health insurance for the aged and disabled, if applicable.	
23. OXYGEN	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
24. ORGAN TRANSPLANTS	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
25. HOME HEALTH CARE	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Limited to 60 visits per member in each benefit year, in- and out-of-network combined.	
26. HOSPICE CARE **a) Inpatient Care**	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
b) Outpatient care	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Bereavement support services for the covered family members during the twelve-month period following the death of the member are limited to a maximum total payment of $1,150. 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. Please see the Hospice section in your certificate for a description of covered services.	

	IN-NETWORK	OUT-OF-NETWORK
27. SKILLED NURSING FACILITY CARE	No coinsurance after deductible.	40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount.
	Limited to 100 visits per member in each benefit year, in- and out-of-network combined.	
28. DENTAL CARE	Not covered	Not covered
29. VISION CARE	Not covered	Not covered
30. CHIROPRACTIC CARE	No coinsurance after deductible. Limited to 12 visits per member in each benefit year combined with acupuncture care (see line 31).	Not covered
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	**Acupuncture care:** No coinsurance after deductible. Limited to 12 visits per member in each benefit year combined with chiropractic care (see line 30).	Not covered
	Benefits are provided for diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams (no coinsurance after deductible). Insulin pumps and related supplies are covered subject to meeting Anthem's medical policy criteria. When diabetic supplies are provided by a pharmacy they are covered under the prescription drug benefit and subject to the prescription copayment. Members who desire another professional opinion may obtain a second surgical opinion.	Benefits are provided for diabetic nutritional counseling, insulin, syringes, needles, test strips, lancets, glucose monitor and diabetic eye exams (40% coinsurance after deductible, plus all charges in excess of the maximum allowed amount). Insulin pumps and related supplies are covered subject to meeting Anthem's medical policy criteria. When diabetic supplies are provided by a pharmacy they are covered under the prescription drug benefit and subject to the prescription copayment. Members who desire another professional opinion may obtain a second surgical opinion.
	Healthy Rewards Listed below are resources Anthem has available for its members to help promote the members well-being. • Complete Health Assessment • Enroll in and graduate from a Personal Health Coach Program • Complete Smoking Cessation Program (for members over the age of 18) • Complete Weight Management Program (for members over the age of 18 with a BMI or 25 or greater)	

PART C: LIMITATIONS AND EXCLUSIONS

32. 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.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	Yes, unless the individual is a HIPAA-eligible individual as defined under federal and state law.

34. HOW DOES THE POLICY DEFINE A "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.
35. 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
36. 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
37. 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.
38. 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.
39. What is the main customer service number?	(866) 837-4597	
40. 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 17549, Denver, CO 80217-7549 (888) 224-4911 Anthem Quality Management 700 Broadway – MC 0532, Denver, CO 80273	
41. 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	
42. 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 #MCOCN477A, individual	
43. 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.

[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

All plans provide coverage for an annual Pap test and the related office visit. Payment for the 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 Plans 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.