



**Looking for
some good
news about
affordable
health
coverage?**

**You've just
found it.**

**Introducing
SmartSense**

Is SmartSense for you?

- Reliable, basic protection with some of our lowest monthly rates
- Choose the annual deductible/monthly rate combination that works for you
- Immediate benefits for first three visits to a doctor
- Choice of prescription drug benefits (Comprehensive Rx or Generic Only Rx)
- Health plan pays up to \$7,000,000 per member in lifetime benefits

What makes Anthem Blue Cross and Blue Shield plans a smart choice?

1. A choice of plans to fit your budget.

No matter where you are in life, we have a plan that will fit your health care needs, as well as your budget.

2. One of the largest networks in Colorado.

With more than 6,500 doctors and more than 80 hospitals throughout the state, the chances are that your doctor is one of ours. And all our network providers have lower rates for our members, so your share of costs will be less.

3. Coverage that travels with you.

No matter where life takes you – whether it's around the state or across the country – Anthem has you covered.

4. Dental and life insurance options.

To enhance your health and financial security, we also offer dental and term life coverage. See page 3 for more information.

5. The Anthem advantage.

You can relax knowing Anthem has been providing quality health care coverage to Colorado residents for many years. We understand your health insurance needs and offer you plans that are backed by the strength, security and stability of Anthem.

Is your doctor in our network?

Go to [anthem.com](https://www.anthem.com) > Colorado > “Find a Doctor.”

What's a PPO plan?

With a PPO (preferred provider organization) health care plan, you'll pay a lower share of your medical expenses when you use doctors or hospitals that participate in our PPO network. Your share of expenses include:

- **Deductible:** Typically this is the amount you have to pay each calendar year for services that your health care plan covers before the plan begins paying. Usually, the higher a plan's deductible is, the lower the monthly premiums are.
- **Family Deductible:** Family plans also have a deductible amount that you pay each calendar year. This amount must be met by two or more family members with no one member contributing more than their individual amount. If any individual family member meets their own deductible before the family deductible is satisfied, the plan would begin to pay for that member's covered services. Once two or more members satisfy the family deductible amount, the plan would begin to pay for the entire family's covered services.
- **Coinsurance:** After your annual deductible is met, this is the percentage of the cost for which you will be responsible for services that your plan covers.
- **Copayment, or Copay:** A flat-dollar amount you pay for covered services.
- **Out-of-Pocket Maximum:** With the SmartSense plan, this is the maximum amount of money (not counting your premiums) that you'll have to pay each year for your covered medical services. Your copays, deductible and coinsurance payments for covered services count toward your out-of-pocket maximum. Once you reach the maximum amount, the plan pays 100% for most in-network medical covered services for the rest of the calendar year.

With a PPO health plan, you can also receive care from a non-participating (non-network) provider, but your share of the cost can be significantly higher.

Prescription drug coverage

The cost of prescription drug drugs can be staggering and is one of the leading causes of rising health care costs. To help control your share of the costs, our SmartSense Plan includes your choice of a generic-only prescription drug benefit, or you may pay extra for the comprehensive benefit, which also covers brand name drugs with a separate deductible.

But even if you purchase the comprehensive prescription drug option, which has coverage for generics and for brand-name prescription drugs, it's still a good idea to consider using generics for the best value. Generic drugs have the same active ingredient as their brand-name equivalents, but normally cost less.

What is a Specialty drug?

Specialty drugs are high cost, scientifically engineered drugs. They are usually injected or infused and require special storage and handling that make them difficult for a typical pharmacy to dispense. Certain Specialty drugs are only available through Anthem's Specialty Pharmacy Network, PrecisionRx Specialty Solutions. If you choose the Comprehensive Prescription Drug option with SmartSense, you'll receive more information about your coverage for Specialty drugs with your enrollment materials.

Plan Benefits		SmartSense	
		In-Network	Out-of-Network
Annual Deductible Choices <i>(separate for In-Network and Out-of-Network)</i>	Individual	\$500 / \$1,500 / \$2,500 / \$5,000 / \$7,500	\$5,000 / \$5,000 / \$5,000 / \$5,000 / \$7,500
	Family	\$1,000 / \$3,000 / \$5,000 / \$10,000 / \$15,000	\$10,000 / \$10,000 / \$10,000 / \$10,000 / \$15,000
		Each family member has an individual deductible. The family deductible can be satisfied by 2 or more members.	
Annual Out-of-Pocket Maximum¹ <i>(includes deductible)</i>	Individual Maximum	\$3,000/\$4,000/\$5,000/\$7,500/\$10,000	\$15,000/\$15,000/\$15,000/\$15,000/\$17,500
	Family Maximum	\$6,000/\$8,000/\$10,000/\$15,000/\$20,000	\$30,000/\$30,000/\$30,000/\$30,000/\$35,000
		Each family member has an individual out-of-pocket maximum. The family out-of-pocket maximum can be satisfied by 2 or more members.	
Lifetime Maximum		Plan pays up to \$7 Million per member	

Covered Services <i>The amounts shown are your share of costs after any deductible</i>	In-Network Coinsurance amounts are percentage of negotiated fee	Out-of-Network Coinsurance amounts are percentage of negotiated fee, plus any amounts charged over that fee
	Doctors' Office Visits	\$30 copay for first 3 visits per member per year <i>(deductible waived)</i> ; after 3 visits and once deductible is met, then 30%
Professional Services <i>(x-ray, lab, anesthesia, surgeon, etc.)</i>	30%	50%
Hospital Inpatient <i>(overnight hospital stays)</i>	30%	50%
Hospital Outpatient <i>(if you don't stay overnight)</i>	30%	50%
Emergency Room Services	30%	30%
Maternity	not covered	
Preventive Care Services <i>(Including appropriate screening for breast, cervical, ovarian, and prostate cancer)</i>	Routine mammogram, Pap and PSA tests: 30% Children's Services: 30%	50%
Physical Therapy, Occupational Therapy and Chiropractic Services	30%	50%
		Plan covers up to a total of 24 visits per year.

Prescription Drug Coverage	In-Network	Out-of-Network
	Comprehensive Prescription Drug Plan	Generic: \$15 copay <i>(or 40%, whichever is greater)</i>
Brand-name/Specialty \$500 annual deductible applies before the following: Brand-name: \$15 copay <i>(or 40%, whichever is greater, not to exceed \$500 per prescription)</i> Specialty: 40% \$5,000 annual out-of-pocket maximum <i>(the most you'll have to pay)</i> In-network only and in addition to brand-name/specialty deductible		
Generic Prescription Drug Plan	Generic Coverage ONLY \$15 copay <i>(or 40%, whichever is greater)</i>	

¹ Excludes non-participating charges in excess of the Anthem negotiated fee and non-participating charges in excess of customary and reasonable fees. Copayments and coinsurance amounts apply to the annual calendar year out-of-pocket maximum except where specifically noted in the policy.

Give yourself every advantage...
good health, a bright smile
and financial security.



Why dental coverage?

Dental care can play an important role in your overall health. Regular checkups and cleanings can help detect the early signs of oral health problems, reduce the risk of permanent damage to your teeth and gums, and prevent costly treatments down the road.

Improve your quality of life, self-confidence and appearance by making good oral health a part of your daily routine and by taking advantage of the benefits offered with our Anthem Blue Dental PPO plan.

This plan gives you coverage for routine check-ups, x-rays and cleaning as soon as you enroll. After you've been covered for six months, you'll get additional coverage for fillings. After twelve months, you'll get coverage for major dental care which can help you save on a lot on procedures like root canals, crowns and dentures.

With the Anthem Blue Dental PPO plan, you may visit any dentist you choose. However, your out-of-pocket costs will usually be less when you use dentists in our network.

**For more information
on our dental plans or
life insurance, ask your
Anthem Agent today!**

Why term life insurance?

Losing a loved one is hard enough without having to worry about financial obligations. Families are often unprepared for this sudden loss, and term life insurance can provide financial support and peace of mind at a difficult time. Here are just a couple of reasons why you'll want to purchase Blue Preferred Life™ from Anthem Life Insurance Company:

- It's inexpensive — just pennies a day
- It's easy — no additional forms are required to enroll

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

Enrollment guidelines for Individual health care plans

To enroll, you must be:

- Age 64 or younger and
- 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

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. 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:

- Nonpayment of premium
- Fraud/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.

What the SmartSense plan does not cover

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. Just ask your Anthem agent for a copy.

Exclusions and Limitations

- Maternity and pregnancy care.
- Conditions covered by workers' compensation or similar law.
- Experimental or investigative services.
- Services provided by a local, state, federal or foreign 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 physical exams, except for preventive care services (e.g., physical exams for insurance, employment, licenses or school are not covered), except as specifically stated in the Certificate.
- Any amounts in excess of the maximum amounts listed in the Certificate.
- 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.
- Contraceptive drugs and/or certain contraceptive devices, except as specifically stated in the Certificate.
- Infertility services.
- 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.
- 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.
- Smoking cessation programs and products.

Ready to Enroll?
Call your Anthem Agent today!

Take a free look

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

Si necesita asistencia o materiales de venta en español, por favor contacte a su agente Anthem Blue Cross and Blue Shield.

This brochure provides a brief summary of benefits and services. If there is any difference between this brochure and the Health Plan Description Form/Certificate, the Certificate will prevail.

Rates and benefits effective 11/15/08 and are subject to change.

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