

2017 Plan Year: Colorado Individual and Family



Your Health Plan Guide

Bronze, Silver, Gold and Catastrophic plans

Looking for a
new health plan?
We can help.



Why Anthem?

Health plans don't have to be complicated.

We understand that every individual and family is unique. That's why we offer many affordable plan options for different health care needs and budgets. Our goal is not just to be there when you're sick, but also to help you stay well – at every stage of life.

With Anthem Blue Cross and Blue Shield (Anthem), you can count on:



A strong network with access to major hospital systems.



Dedicated customer service.



All your benefits, including dental and vision, from one source.



Competitive pricing.



Convenient online tools, including 24/7 access to doctors through LiveHealth Online.



A simple enrollment process.



Coordinated care that connects your doctors and other health care providers.



Resources to support your health care goals.



Statewide options and greater savings with the Pathway network

The statewide HMO Pathway network provides a wide range of doctors and health providers across Colorado:

- Includes 58 acute care hospitals, more than 1,800 PCPs and more than 8,300 specialists
- Access to the same powerful network options that make up our HMO Colorado network outside the Front Range

* Based on Internal Data, 2016.

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







- Medical plans
- Networks
- Find a Doctor
- Prescriptions

What we cover

All our plan options have one major goal — to help you stay healthy and provide the quality coverage you need, when you need it. That's why, no matter which plan you choose, you're covered from preventive care to emergencies and plenty in between!

Built in benefits





Our plans include the essential health benefits (EHBs) mandated by the Affordable Care Act (ACA):

-  Ambulatory patient services (outpatient care you get without being admitted to a hospital)
-  Emergency services (going to the emergency room, also known as the ER) or urgent care center, when medically necessary
-  Hospitalization and inpatient services (such as surgery)
-  Laboratory and radiology services (includes blood work, screenings and X-rays)
-  Mental health and substance use disorder services (includes counseling and psychotherapy)
-  Pediatric dental and vision coverage for children up to age 19^{†‡}



Take care of yourself with no-cost, in-network preventive care

With Anthem, you pay no copay, no coinsurance and no deductible for covered **in-network** preventive services. So you can stay on top of your health care and your finances!*

-  Pregnancy, maternity and newborn care (care before, during and after pregnancy)
-  Prescriptions
-  Rehabilitative and habilitative services and devices (hospital beds, crutches, oxygen tanks)
-  Visits to doctors in your plan for preventive care services* (wellness exams, shots, screenings) and chronic disease management

* Nationally recommended preventive care services from in-network providers have no copay, no coinsurance and no deductible requirement. Preventive and wellness services consist of certain services, including well-child care, immunizations, prostate-specific antigen (PSA) screenings, Pap tests, mammograms and more, recommended by the United States Preventive Services Task Force.

† If you choose a medical plan with out-of-network benefits, embedded dental benefits will also be available through out-of-network providers. If you choose a plan that only includes in-network benefits, the dental benefits will only be available through in-network providers. Remember, you save money when using in-network providers no matter which type of medical plan you choose.

‡ The **pediatric dental** policy DOES NOT provide any dental benefits to individuals age 19 or older. The pediatric dental policy is offered, so the purchaser will have pediatric dental coverage as required by the ACA. A person age 19 or older will need to buy a separate adult plan if they want adult dental benefits. The pediatric dental policy WILL NOT pay for any adult dental care.

Pharmacy

Getting the most out of your pharmacy benefits can help keep you healthy and save you money. Here's what you need to know:

About our covered drug list

Anthem's pharmacy plans have a formulary/drug list, which is a list of covered prescription drugs that includes hundreds of brand name and generic medicines. Our individual and family plans use the Select Drug List, which offers drugs in every category and class that meet or exceed ACA requirements. The list tells you what tier your drug is in and provides guidance on how your cost shares are affected. Cost shares usually go up the higher the drug tier. Talk to your doctor about possible lower-cost options if your drug is in a higher tier.

Access all of your pharmacy information at [anthem.com](https://www.anthem.com)

- Find out if your medication is covered. Check out our Select Drug List at [anthem.com/COSelectdrugtier4](https://www.anthem.com/COSelectdrugtier4).
- See if your preferred pharmacy is in the plan's network. Visit [anthem.com/pharmacyinformation](https://www.anthem.com/pharmacyinformation) and select the **Rx Networks** tab.
- Learn more about using your pharmacy benefits, your drug list and get answers to questions about prior authorization and step therapy. See our list of FAQs located on the **Customer Support** tab.

Together with medical – better and easier than ever

With our combined pharmacy and medical programs, your doctor has a better picture of your health which can help result in:

- Better overall health
- A simplified experience
- Fewer hospital stays and reduced medical costs*
- Increased cost savings for prescriptions*



Save with prescription drug benefits

Anthem wants to help lower the cost of your prescription drugs, improve your overall health and deliver top-notch customer service. Here's how:

A retail pharmacy network with two coverage levels helps provide savings and access

Level 1

Visiting CVS, Target, Wal-Mart, Kroger (King Soopers), Safeway, or any of our nearly 20,000 Level 1 in-network pharmacies give you the lowest out-of-pocket costs for your prescriptions.

Level 2

You can also visit one of our 50,000+ Level 2 in-network pharmacies, and your prescriptions will be covered for an additional cost.[†]

Go to [anthem.com/pharmacyinformation](https://www.anthem.com/pharmacyinformation) and select the **Rx Networks** tab to see if your preferred pharmacy is in Level 1 or Level 2. You'll save money by choosing a Level 1 pharmacy.

Save with Home Delivery Choice

We offer home delivery of your medicines right to your door. With the Home Delivery Choice program, you must choose how you want to get the medicines you take for ongoing conditions like indigestion, high blood pressure, high cholesterol or diabetes – at your local pharmacy or delivered to your doorstep.

We'll contact you by phone and mail to tell you about the program and its benefits. You can use a retail pharmacy for two fills, but after the second fill, your medicines will no longer be covered at your pharmacy until you make a final decision.

Using home delivery may help you save money. And it makes it easy for you to get your medicine quickly and safely.

* Results based on 2014 clinical and cost-of-care programs for enterprise commercial business; medical cost offsets based on Medication Review.

† Additional \$10 copayment or 10% coinsurance may apply.

How to choose a plan

Networks...why choosing a doctor in your plan matters

One thing to think about when shopping for a health plan is your health plan's network of participating providers.

When Anthem sets up medical, dental and vision networks, we negotiate with doctors, hospitals and labs on the cost of services. For example, a doctor may normally charge \$150 for an X-ray for a patient without medical benefits. We may negotiate with that same doctor to discount the rate for our Anthem members down to \$100. Once this agreement is made, the doctor becomes part of our network of health care providers.

Bottom line: If you have a favorite doctor, hospital or other health care provider, you should always check to see if that provider is in our network.

Providers in your plan may include:



Doctors, therapists, mental health providers and other health care professionals



Hospitals and outpatient facilities



Pharmacies



ERs and urgent care centers



Labs and radiology centers



Durable medical equipment, like hospital beds, crutches, wheelchairs and oxygen tanks (retail and online stores)



Our Find a Doctor tool — it's quick and easy

Go to [anthem.com/findadoctor](https://www.anthem.com/findadoctor) and search using the plan/network you're considering (**Anthem Pathway, Mountain Enhanced or PPO Catastrophic**).

You'll get a list of providers, including detailed information about them like location, gender, specialty, certifications, availability and much more. Network availability may depend on where you live.



For searches on the go, download our **Anthem Anywhere** mobile app to your mobile device.

Types of networks

Depending on what type of plan you choose, your benefits and provider choices may be different:

- **Pathway and Mountain Enhanced networks:** With our health maintenance organization (HMO) plans, you have access to a wide range of doctors, health care providers and plans based on where you live in Colorado.

You have to choose a primary care doctor, but a referral is not required to see other in-network doctors. HMOs don't offer out-of-network benefits, except for emergency and urgent care or when a service is preapproved. If you go outside the network for any other reason, you'll have to pay 100% out of pocket.
- With our **PPO Catastrophic** plan (available off the Marketplace only), you get access to our widest network of doctors and hospitals in Colorado. You choose a primary care doctor to manage your care needs, but no referrals are required. This plan is available to people under age 30 or who qualify for a hardship exemption.

Travel coverage

Whether you're traveling for work or on vacation, going to the ER or urgent care is probably the last thing you want to worry about. The good news is you don't have to! With the Blue Cross and Blue Shield Association's BlueCard® program, you can access care no matter where you are in the U.S.

In the U.S.

All of our plans cover medically necessary emergency and urgent care in all 50 states.

Our PPO Catastrophic plan also includes coverage for non-emergency care across the U.S. You can see any provider you wish, but you'll pay less out of pocket when you visit participating BlueCard providers and hospitals.

Guest Membership/Away From Home Care when temporarily living out of state - HMO

Will you or a family member be living away from home and outside of your health plan's service area for more than 90 days? With our HMO plans, we can cover you. Just ask for a guest membership (also known as Away From Home Care) to one of our affiliated Blue Cross and Blue Shield plans in that area.

A guest membership lets you become a "guest" of that other health plan and enjoy its benefits and coverage. It comes in handy for students going to college in another state. After you're a member, call Guest Membership at 800-827-6422 to learn more. Guest memberships aren't available in all areas.



The difference between doctors in the plan and doctors outside the plan

Doctors in the plan:

Doctors and other health care providers who contract with us to provide care at discounted rates.

Doctors outside the plan:





Doctors and other health care providers who are not contracted with the health plan.

If you choose to go to a doctor not in your plan, you'll pay more out of pocket.

What do you need?

Choosing the right health care plan can be challenging. To help you decide, consider the questions below. And remember, your broker or Anthem representative can provide answers and give advice.

What matters most to you?

-  **Does the plan meet your coverage needs?** How often do you see doctors and specialists? What prescription medications do you take regularly? Are you planning any procedures this year?
-  **Do you have a certain doctor you like to see?** If you answered yes, then you can use our Find a Doctor tool at [anthem.com/findadoctor](https://www.anthem.com/findadoctor) to check if your doctor is in the plan you're considering.
-  **Do you need to know if your medication is covered?** Check out our drug list at [anthem.com/COSelectdrugtier4](https://www.anthem.com/COSelectdrugtier4).
-  **Is a Catastrophic plan an option?** If you're under age 30 or are 30 or older with an approved hardship exemption from Connect for Health Colorado (your state's Marketplace) you may qualify for a high deductible, low monthly payment, Catastrophic plan. Catastrophic plans can help protect you from worst-case scenarios like serious accidents or illnesses.

Plan choices

Metal Levels



Health savings account (HSA)

If you like the idea of lowering your health care costs and your taxes, a health savings account (HSA) could be a good option for you.

- **What is it?**
It's a savings account you can open when you have a qualified high-deductible health plan (HDHP). You set up the HSA through a bank and fund it with your post tax dollars.
- **Why choose it?**
It can help you pay for health care expenses, including prescriptions. Plus, you can claim your HSA contributions as tax deductions, earn interest on your money and roll over the year-end balance.
- **How can you learn more?**
Check with your tax advisor to see if an HSA plan is right for you. For more information on HSAs, review our HSA flier included with this brochure.

How your plan might work

With most health care plans, you pay a monthly fee called a premium; then, you share some of the cost of covered services you receive with your health insurance company. **With Anthem, you choose the level of cost sharing that works for you.**

Here's an example: Meet Jason*

To show you how your health plan might work, we'd like to introduce you to "Jason." The cost-share amounts used in this example may not apply to the plan you choose. This is just an example. Be sure to look at the actual benefits for each plan when you're deciding.

Jason's story

After injuring his knee in a soccer game, Jason chooses a doctor in our network, which saves him the most money. Jason pays a copay or coinsurance based on Anthem negotiated rates because he uses doctors in our network. **Below, see how Jason's benefits work, his treatment costs and why it's important to have health insurance:***

Jason's health plan has the following benefits:

- \$2,000 deductible
- 30% coinsurance
- \$5,000 out-of-pocket limit
- \$35 copay for primary care doctor visits



Copay On some plans, you pay a fixed-dollar amount or copay for certain services. For example, you may have a \$35 copay for in-network primary care doctor visits.	Let's take a closer look at Jason's doctor visit: <ul style="list-style-type: none">◦ Doctor visit cost (without insurance): \$200◦ Anthem's negotiated rate: \$140◦ Anthem pays: \$105▶ Jason paid: \$35 (This is his plan's copay for primary care doctor office visits.)
Deductible You pay this amount for covered medical services each calendar year, from January 1 through December 31. Your deductible starts over each calendar year. Examples of covered services that apply to the deductible include lab work, X-rays, anesthesia and surgeon fees.	Here's what happens when Jason's doctor orders an approved magnetic resonance imaging (MRI) of the knee and recommends surgery: MRI <ul style="list-style-type: none">◦ MRI cost (without insurance): \$1,500◦ Anthem's negotiated rate: \$1,000▶ Jason paid: \$1,000 (Jason's payment counts toward his plan's \$2,000 deductible.) Surgery <ul style="list-style-type: none">◦ Hospital/surgery costs (without insurance): \$50,000◦ Anthem's negotiated rate: \$35,000▶ Jason paid: \$1,000 (Jason's payment satisfies the remaining \$1,000 deductible.)◦ Remaining cost of surgery: \$34,000

Coinsurance (your percentage of the cost)

Once you've met your deductible, Anthem starts paying a portion of your claims. Then, you and Anthem share responsibility for your health care bills. Your coinsurance is the percentage that you must pay for certain covered services. Having met his deductible, Jason begins to pay coinsurance on covered services that require it.

Out-of-pocket limit

This is the most you pay during a calendar year for covered services. Your combined deductible, coinsurance and copay costs typically make up your out-of-pocket limit. Once you meet this limit, your health insurance covers 100% (of the maximum allowed amount) of covered services for the rest of the calendar year.

Summary

Jason paid far less out of pocket because he had health care coverage and stayed in our network. If Jason had used a doctor outside our network, he would have paid more.

Keep in mind if your plan doesn't include coverage for out-of-network benefits, you'll pay the full cost for services from doctors not in our network with the exception of medically necessary emergency and urgent care.

Let's check in to see Jason's final costs for surgery:

- *Coinsurance* (30% of \$34,000): \$10,200
- ▶ **Jason paid:** **\$2,965**
(Jason's payment satisfies the remainder of his \$5,000 out-of-pocket limit. Even though Jason's coinsurance is 30% or \$10,200, he only has to pay a portion of that to meet his \$5,000 out-of-pocket limit.)

Jason has met his in-network out-of-pocket limit and the remaining surgery costs are paid by Anthem:

- *Anthem pays:* \$31,035
- *Jason's out-of-pocket limit:* \$5,000

Let's check in to see Jason's final costs:

- *Total for the doctor visit, MRI and surgery (without health insurance):*
. \$51,700
- *Total Anthem paid after discounts:* \$31,140
- ▶ **Total Jason paid:** **\$5,000**
(\$35 office visit + \$2,000 deductible + \$2,965 coinsurance = \$5,000)

Call your broker or Anthem representative for more information.

You can also visit [anthem.com](https://www.anthem.com) to view and compare different plans.

Qualify for financial help?

With the Affordable Care Act (ACA), most people have to get health care coverage unless they qualify for an exemption. But you may be eligible for financial help to pay for your insurance.

Your medical plan may not cost as much as you think

Depending on your income and family size, you may qualify for an advance premium tax credit (APTC) on any metal level plan, excluding Catastrophic plans, when you buy a plan through Connect for Health Colorado. If you qualify, you may be able to enroll in certain Silver plans available on Connect for Health Colorado that offer a reduction in the deductible, copays and out-of-pocket costs charged under that plan. This is called a cost-share reduction (CSR) plan (also called cost-sharing subsidy). These options are shown in the chart below as S04, S05 and S06.

Use the chart below to see if you qualify for a cost-sharing subsidy.

1. Find your family size. Then, figure out your yearly income and move across the row to find the income range that applies to your household.
2. Look at the percentage at the top of the chart to see where you fall on the Federal Poverty Level (FPL).
3. Move up to the second row to find the plan you qualify for.*

2017 Federal Poverty Level

	Less than 138%		138% - 150%	151% - 200%	201% - 250%
You qualify for	Medicaid Eligible		S06	S05	S04
Family Size					
1	\$11,880	\$16,394	\$16,395-\$17,820	\$17,821-\$23,760	\$23,761-\$29,700
2	\$16,020	\$22,108	\$22,109-\$24,030	\$24,031-\$32,040	\$32,041-\$40,050
3	\$20,160	\$27,821	\$27,822-\$30,240	\$30,241-\$40,320	\$40,321-\$50,400
4	\$24,300	\$33,534	\$33,535-\$36,450	\$36,451-\$48,600	\$48,601-\$60,750
5	\$28,440	\$39,247	\$39,248-\$42,660	\$42,661-\$56,880	\$56,881-\$71,100
6	\$32,580	\$44,960	\$44,961-\$48,870	\$48,871-\$65,160	\$65,161-\$81,450
7	\$36,730	\$50,687	\$50,688-\$55,095	\$55,096-\$73,460	\$73,461-\$91,825
8	\$40,890	\$56,428	\$56,429-\$61,335	\$61,336-\$81,780	\$81,781-\$102,225

* Other medical plans are available, but are not eligible for a subsidy or cost-share reduction.

Avoid tax penalties

If you don't enroll in a medical plan, you may have to pay a penalty – unless you qualify for an exemption. Penalties are based on your income and increase each year for inflation. To learn how tax penalties could affect you, contact a tax advisor.

What does it mean to shop on or off the Marketplace?

The medical plans you see in this brochure are only available off Connect for Health Colorado.

Does the chart show you qualify for a Silver CSR plan? Then, you'll need to shop on Connect for Health Colorado. You can still buy an Anthem plan at [ConnectforHealthCO.com](https://connectforhealthco.com), where you can take advantage of an APTC or Silver CSR plan, if you qualify.

Whether you shop on or off the Marketplace, you can compare plans and get a quote on the plan that fits your needs. Visit anthemchoices.com or contact your broker or Anthem representative to find a plan that is right for you or to find out if you are eligible for a CSR.

Overview of plans

Understanding insurance terms

In-network preventive care is covered at no additional cost to you!*

Insurance terms can be confusing. Here's a quick look at some commonly used health insurance terms.

Take a look at the following pages to see the individual and family medical plan choices offered by Anthem, including a sample of commonly used benefits and how they're covered under each plan. **Cost-share and benefit information shown is for *in-network* services only.**

For more information, contact your broker or Anthem representative. You can also view and compare plans on [anthem.com](https://www.anthem.com).

Plan name	Plan name and contract code are found in the first row of the medical plan charts. Look for this when you're applying for a plan. The contract code is in parentheses after the plan name.
Plan includes out-of-network coverage?	Indicates whether the plan includes coverage for out-of-network benefits. In-network refers to doctors who are part of the plan's network. Out-of-network refers to doctors who don't participate in the network.
Deductible	<p>The deductible is a set amount that you pay out of pocket each year before your plan starts paying for covered services, except for in-network preventive services.* <i>For example:</i> If your deductible is \$5,000, your plan won't pay anything until you've met your \$5,000 deductible for covered health care services. Some plans may cover certain services, such as doctor office visits, before you meet the deductible.</p> <p>Our plans have embedded family deductibles, where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, before receiving plan benefits. No one family member pays more than the individual deductible. The medical plan charts display the individual deductible. Family deductibles are two (2) times the individual amount for most plans and three (3) times the individual amount for Gold plans.</p> <p>Note: You must meet your deductible every calendar year (January 1 through December 31), even if your effective date (the date your coverage begins) is later than January 1.</p>
Out-of-pocket limit	<p>The out-of-pocket limit is the most you pay during a policy period (each calendar year) before your health insurance or plan pays 100% of the maximum allowed amount. <i>For example:</i> If your out-of-pocket limit is \$6,850, you will continue to pay your coinsurance and copays, if applicable, until you've met your \$6,850 out-of-pocket limit. Once you have met your out-of-pocket limit, your plan pays 100% of the maximum allowed amount for covered services for the rest of that calendar year.</p> <p>This limit never includes your monthly payment (premium), additional charges from the doctor (balance billing), or services your plan doesn't cover. The amount includes deductible, copays, coinsurance and pharmacy costs. The medical plan charts display the individual out-of-pocket limit. Family out-of-pocket limits are two (2) times the individual amount.</p>
Coinsurance	<p>Your percentage of the cost (Coinsurance) is the amount you pay for covered health care services. It's a percentage of the cost of services after the deductible has been paid. <i>For example:</i> A health plan pays 80% of the maximum allowed amount for a service and you pay the remaining 20%. All medical plans have coinsurance, but the percentage may vary by health care service.</p>
Copay	<p>A copay is a fixed fee that you pay out of pocket for each visit to a health care provider. <i>For example:</i> If your copay is \$50, then you pay \$50 when you see your in-network doctor — usually at the time you receive treatment. The amount of your copay may depend on the type of health care service you receive.</p>

* Nationally recommended preventive care services from in-network providers have no copay, no coinsurance and no deductible requirement. Preventive and wellness services consist of certain services, including well-child care, immunizations, prostate-specific antigen (PSA) screenings, Pap tests, mammograms and more, recommended by the United States Preventive Services Task Force.

Medical plans - HMO

The benefit information shown here is for in-network services. **Pathway** and **Mountain Enhanced** network plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with these HMO plans.

Mountain Enhanced network plans are available in the following communities only: Archuleta county (Pagosa Springs), La Plata county (Durango), Montezuma county (Cortez), Summit county (Keystone/Frisco/Breckenridge) and Eagle county (Vail Valley).

	Anthem Bronze Mountain Enhanced HMO 5000 (1JR7)	Anthem Bronze Pathway HMO 5000 (1G0P)	Anthem Bronze Pathway HMO 5000 for HSA (1G0V)
Network name	Mountain Enhanced	Pathway	Pathway
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$5,000	\$5,000	\$5,000
Individual out-of-pocket limit	\$7,150	\$7,150	\$6,550
Coinsurance (percentage may vary for some covered services)	40%	40%	25%
Preventive care ¹	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) ² (Other office services may be subject to deductible and plan coinsurance)	\$50 copay per visit for the first 2 visits, then deductible and 40% coinsurance	\$50 copay per visit for the first 2 visits, then deductible and 40% coinsurance	Deductible, then 25% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 25% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 25% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then \$250 copay and 40% coinsurance	Deductible, then \$250 copay and 40% coinsurance	Deductible, then \$250 copay and 25% coinsurance
Urgent care	Deductible, then \$50 copay and 40% coinsurance	Deductible, then \$50 copay and 40% coinsurance	Deductible, then \$50 copay and 25% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then \$200 copay and 40% coinsurance	Deductible, then \$200 copay and 40% coinsurance	Deductible, then \$500 copay and 25% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then \$1,000 copay and 40% coinsurance	Deductible, then \$1,000 copay and 40% coinsurance	Deductible, then 25% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 25% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1³: level 1 / level 2	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance	25% coinsurance / 35% coinsurance
Retail pharmacy tier 2³: level 1 / level 2	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance	25% coinsurance / 35% coinsurance
Retail pharmacy tier 3³: level 1 / level 2	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance	25% coinsurance / 50% coinsurance
Retail pharmacy tier 4: level 1 / level 2	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance	25% coinsurance / 50% coinsurance
Physical and occupational therapy ⁴ (limits apply)	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 25% coinsurance
Speech therapy ⁴ (limits apply)	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 25% coinsurance

Please see Medical plans footnotes on page 19.

Medical plans - HMO

The benefit information shown here is for in-network services. **Pathway** and **Mountain Enhanced** network plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with these HMO plans.

Mountain Enhanced network plans are available in the following communities only: Archuleta county (Pagosa Springs), La Plata county (Durango), Montezuma county (Cortez), Summit county (Keystone/Frisco/Breckenridge) and Eagle county (Vail Valley).

	Anthem Bronze Pathway HMO 5400 (1X7C)	Anthem Bronze Pathway HMO 5800 (1G0R)	Anthem Bronze Pathway HMO 6300 for HSA (1G0T)
Network name	Pathway	Pathway	Pathway
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$5,400	\$5,800	\$6,300
Individual out-of-pocket limit	\$7,150	\$7,150	\$6,550
Coinsurance (percentage may vary for some covered services)	50%	30%	0%
Preventive care ¹	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) ² (Other office services may be subject to deductible and plan coinsurance)	\$50 copay per visit for the first 2 visits, then deductible and 50% coinsurance	\$45 copay per visit for the first 2 visits, then deductible and 30% coinsurance	Deductible, then 0% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 50% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 50% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then \$250 copay and 50% coinsurance	Deductible, then \$500 copay and 30% coinsurance	Deductible, then \$200 copay
Urgent care	Deductible, then \$75 copay and 50% coinsurance	Deductible, then \$50 copay and 30% coinsurance	Deductible, then 0% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then \$500 copay and 50% coinsurance	Deductible, then \$200 copay and 30% coinsurance	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then \$1,450 copay	Deductible, then \$500 copay and 40% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 50% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies
Retail Pharmacy tier 1³: level 1 / level 2	\$15 copay / \$25 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 10% coinsurance
Retail pharmacy tier 2³: level 1 / level 2	\$60 copay / \$70 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 10% coinsurance
Retail pharmacy tier 3³: level 1 / level 2	\$150 copay / \$160 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 50% coinsurance
Retail pharmacy tier 4: level 1 / level 2	\$500 copay / \$510 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 50% coinsurance
Physical and occupational therapy ⁴ (limits apply)	Deductible, then 50% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Speech therapy ⁴ (limits apply)	Deductible, then 50% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance

Please see Medical plans footnotes on page 19.

Medical plans - HMO

The benefit information shown here is for in-network services. **Pathway** and **Mountain Enhanced** network plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with these HMO plans.

Mountain Enhanced network plans are available in the following communities only: Archuleta county (Pagosa Springs), La Plata county (Durango), Montezuma county (Cortez), Summit county (Keystone/Frisco/Breckenridge) and Eagle county (Vail Valley).

	Anthem Silver Pathway HMO 1300 (1G1G)	Anthem Silver Mountain Enhanced HMO 2000 (1JR2)	Anthem Silver Pathway HMO 2000 (1G1B)
Network name	Pathway	Mountain Enhanced	Pathway
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$1,300	\$2,000	\$2,000
Individual out-of-pocket limit	\$7,150	\$6,350	\$6,350
Coinsurance (percentage may vary for some covered services)	35%	25%	25%
Preventive care ¹	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) ² (Other office services may be subject to deductible and plan coinsurance)	\$35 copay per visit for the first 2 visits, then deductible and 35% coinsurance	\$35 copay	\$35 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then \$250 copay and 35% coinsurance	Deductible, then \$250 copay and 25% coinsurance	Deductible, then \$250 copay and 25% coinsurance
Urgent care	Deductible, then \$50 copay and 35% coinsurance	Deductible, then \$50 copay and 25% coinsurance	Deductible, then \$50 copay and 25% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then \$200 copay and 35% coinsurance	Deductible, then \$200 copay and 25% coinsurance	Deductible, then \$200 copay and 25% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then \$500 copay and 40% coinsurance	Deductible, then \$500 copay and 30% coinsurance	Deductible, then \$500 copay and 30% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1³: level 1 / level 2	\$10 copay / \$20 copay	25% coinsurance / 35% coinsurance	25% coinsurance / 35% coinsurance
Retail pharmacy tier 2³: level 1 / level 2	\$40 copay / \$50 copay	25% coinsurance / 35% coinsurance	25% coinsurance / 35% coinsurance
Retail pharmacy tier 3³: level 1 / level 2	\$80 copay / \$90 copay	25% coinsurance / 50% coinsurance	25% coinsurance / 50% coinsurance
Retail pharmacy tier 4: level 1 / level 2	\$500 copay / \$510 copay	25% coinsurance / 50% coinsurance	25% coinsurance / 50% coinsurance
Physical and occupational therapy ⁴ (limits apply)	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Speech therapy ⁴ (limits apply)	Deductible, then 35% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance

Please see Medical plans footnotes on page 19.

Medical plans - HMO

The benefit information shown here is for in-network services. **Pathway** and **Mountain Enhanced** network plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with these HMO plans.

Mountain Enhanced network plans are available in the following communities only: Archuleta county (Pagosa Springs), La Plata county (Durango), Montezuma county (Cortez), Summit county (Keystone/Frisco/Breckenridge) and Eagle county (Vail Valley).

	Anthem Silver Pathway HMO 2000/20% (1G1R)	Anthem Silver Pathway HMO 2500 (1G1M)	Anthem Silver Pathway HMO 3200 (1X7M)
Network name	Pathway	Pathway	Pathway
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$2,000	\$2,500	\$3,200
Individual out-of-pocket limit	\$7,150	\$7,150	\$4,200
Coinsurance (percentage may vary for some covered services)	20%	15%	50%
Preventive care ¹	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) ² (Other office services may be subject to deductible and plan coinsurance)	\$35 copay per visit for the first 2 visits, then deductible and 20% coinsurance	\$40 copay per visit for the first 3 visits, then deductible and 15% coinsurance	Deductible, then 50% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 50% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 50% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then \$250 copay and 20% coinsurance	Deductible, then \$500 copay and 15% coinsurance	Deductible, then \$200 copay and 50% coinsurance
Urgent care	Deductible, then \$50 copay and 20% coinsurance	Deductible, then \$50 copay and 15% coinsurance	Deductible, then \$75 copay and 50% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then \$500 copay and 20% coinsurance	Deductible, then \$500 copay and 15% coinsurance	Deductible, then \$500 copay and 50% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 30% coinsurance	Deductible, then \$500 copay and 30% coinsurance	Deductible, then \$1,000 copay
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 50% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: No deductible
Retail pharmacy tier 1³: level 1 / level 2	\$15 copay / \$25 copay	\$10 copay / \$20 copay	\$10 copay / \$20 copay
Retail pharmacy tier 2³: level 1 / level 2	\$40 copay / \$50 copay	\$40 copay / \$50 copay	\$40 copay / \$50 copay
Retail pharmacy tier 3³: level 1 / level 2	\$80 copay / \$90 copay	\$80 copay / \$90 copay	\$80 copay / \$90 copay
Retail pharmacy tier 4: level 1 / level 2	\$500 copay / \$510 copay	\$500 copay / \$510 copay	\$500 copay / \$510 copay
Physical and occupational therapy ⁴ (limits apply)	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 50% coinsurance
Speech therapy ⁴ (limits apply)	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 50% coinsurance

Please see Medical plans footnotes on page 19.

Medical plans - HMO

The benefit information shown here is for in-network services. **Pathway** and **Mountain Enhanced** network plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with these HMO plans.

Mountain Enhanced network plans are available in the following communities only: Archuleta county (Pagosa Springs), La Plata county (Durango), Montezuma county (Cortez), Summit county (Keystone/Frisco/Breckenridge) and Eagle county (Vail Valley).

	Anthem Silver Core Mountain Enhanced HMO 5300 (2K4L)	Anthem Silver Core Pathway HMO 5300 (2EP8)	Anthem Gold Pathway HMO 0 (1X7J)
Network name	Mountain Enhanced	Pathway	Pathway
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$5,300	\$5,300	\$0
Individual out-of-pocket limit	\$6,450	\$6,450	\$6,900
Coinsurance (percentage may vary for some covered services)	25%	25%	30%
Preventive care ¹	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) ² (Other office services may be subject to deductible and plan coinsurance)	\$35 copay	\$35 copay	\$30 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	\$60 copay
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	30% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	\$250 copay, then 30% coinsurance
Urgent care	Deductible, then \$50 copay	Deductible, then \$50 copay	\$100 copay
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	\$500 copay
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	\$1,000 copay
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	30% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: No deductible
Retail pharmacy tier 1³: level 1 / level 2	\$10 copay / \$20 copay	\$10 copay / \$20 copay	\$10 copay / \$20 copay
Retail pharmacy tier 2³: level 1 / level 2	\$40 copay / \$50 copay	\$40 copay / \$50 copay	\$40 copay / \$50 copay
Retail pharmacy tier 3³: level 1 / level 2	35% coinsurance / 50% coinsurance	35% coinsurance / 50% coinsurance	\$80 copay / \$90 copay
Retail pharmacy tier 4: level 1 / level 2	50% coinsurance / 50% coinsurance	50% coinsurance / 50% coinsurance	\$500 copay / \$510 copay
Physical and occupational therapy ⁴ (limits apply)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	30% coinsurance
Speech therapy ⁴ (limits apply)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	30% coinsurance

Please see Medical plans footnotes on page 19.

Medical plans - HMO

The benefit information shown here is for in-network services. **Pathway** and **Mountain Enhanced** network plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with these HMO plans.

Mountain Enhanced network plans are available in the following communities only: Archuleta county (Pagosa Springs), La Plata county (Durango), Montezuma county (Cortez), Summit county (Keystone/Frisco/Breckenridge) and Eagle county (Vail Valley).

	Anthem Gold Mountain Enhanced HMO 1100 (1G2F)	Anthem Gold Pathway HMO 1100 (1G24)	Anthem Gold Pathway HMO 1500 (1X7F)
Network name	Mountain Enhanced	Pathway	Pathway
Plan includes out-of-network coverage?	No	No	No
Individual deductible	\$1,100	\$1,100	\$1,500
Individual out-of-pocket limit	\$7,000	\$7,000	\$3,750
Coinsurance (percentage may vary for some covered services)	10%	10%	20%
Preventive care ¹	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) ² (Other office services may be subject to deductible and plan coinsurance)	\$25 copay	\$25 copay	\$30 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then \$250 copay and 10% coinsurance	Deductible, then \$250 copay and 10% coinsurance	Deductible, then \$500 copay and 20% coinsurance
Urgent care	Deductible, then \$50 copay and 10% coinsurance	Deductible, then \$50 copay and 10% coinsurance	\$90 copay
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then \$500 copay and 10% coinsurance	Deductible, then \$500 copay and 10% coinsurance	Deductible, then \$500 copay and 20% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then \$500 copay and 20% coinsurance	Deductible, then \$500 copay and 20% coinsurance	Deductible, then \$500 copay and 40% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: No deductible
Retail pharmacy tier 1³: level 1 / level 2	\$10 copay / \$20 copay	\$10 copay / \$20 copay	\$10 copay / \$20 copay
Retail pharmacy tier 2³: level 1 / level 2	\$40 copay / \$50 copay	\$40 copay / \$50 copay	\$40 copay / \$50 copay
Retail pharmacy tier 3³: level 1 / level 2	\$80 copay / \$90 copay	\$80 copay / \$90 copay	\$80 copay / \$90 copay
Retail pharmacy tier 4: level 1 / level 2	\$500 copay / \$510 copay	\$500 copay / \$510 copay	\$500 copay / \$510 copay
Physical and occupational therapy ⁴ (limits apply)	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance
Speech therapy ⁴ (limits apply)	Deductible, then 10% coinsurance	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance

Please see Medical plans footnotes on page 19.

Medical plans - HMO and PPO (Catastrophic plans)

Pathway and Mountain Enhanced network plans only include out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with these HMO plans.

Mountain Enhanced network plans are available in the following communities only: Archuleta county (Pagosa Springs), La Plata county (Durango), Montezuma county (Cortez), Summit county (Keystone/Frisco/Breckenridge) and Eagle county (Vail Valley).

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

	Anthem Catastrophic Pathway HMO 7150 (1G27)	Anthem Catastrophic PPO 7150 (2KVD)
Network name	Pathway	Anthem PPO
Plan includes out-of-network coverage?	No	Yes
Individual deductible	\$7,150	\$7,150 / \$20,550 In-network / Out-of-network
Individual out-of-pocket limit	\$7,150	\$7,150 / \$21,450 In-network / Out-of-network
Coinsurance (percentage may vary for some covered services)	0%	0% / 50% In-network / Out-of-network
Preventive care ¹	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP) ² (Other office services may be subject to deductible and plan coinsurance)	\$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance	\$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Urgent care	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1³: level 1 / level 2	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2³: level 1 / level 2	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3³: level 1 / level 2	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 4: level 1 / level 2	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance
Physical and occupational therapy ⁴ (limits apply)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Speech therapy ⁴ (limits apply)	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance

Please see Medical plans footnotes on page 19.

Medical plans benefit footnotes

1 Nationally recommended **preventive care services** from in-network providers have no copay, no coinsurance and no deductible requirement. Preventive and wellness services consist of certain services, including well-child care, immunizations, prostate-specific antigen (PSA) screenings, Pap tests, mammograms and more, recommended by the United States Preventive Services Task Force.

2 **LiveHealth Online** web visits have the same PCP office visit cost share listed in the chart.

3 **Home delivery pharmacy** cost shares are 2.5 times the retail copay for Tier 1 drugs and 3 times the retail copay for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays.

4 **Physical, occupational or speech outpatient therapy** limited to up to 20 visits for each therapy per year for **rehabilitation services**. A separate 20 visit limit for each therapy per year applies to **habilitation services**. From birth until the member's sixth birthday, both of these benefits are provided as required by applicable law.



Dental

We offer a variety of individual and family dental plans to fit your health care needs and budget:

- Dental Prime*
- Anthem Dental Family Value
- Anthem Dental Family
- Anthem Dental Family Enhanced

Anthem can help you get access to the dental care you need for your overall health. Many of our dental plans cover you 100% for exams, cleanings and X-rays. Plus, we have one of the largest dental preferred provider organization (PPO) networks in the country. To see more of what we cover, take a look at our **Dental stand-alone plans** on the next page.

Tools that put a smile on your face

We offer some great online tools to help you better understand your dental health. Once you're a member, log in to the web address on your ID card to access:



Ask a Hygienist

Email questions to licensed dental professionals and get quick, private personalized advice at no extra cost.



Dental Cost Estimator

Help estimate your costs for certain dental procedures and services in the ZIP code where you get care.



Dental Health Assessment

Get feedback based on your unique responses to a few questions to help you keep a healthy smile.



Vision

You can add Blue View VisionSM benefits to any Anthem medical or dental plan. These plans feature:

- **A broad national network** — More than 33,000 participating private practice doctors[†] at over 26,000 locations, including online choices at Glasses.com, ContactsDirect or 1-800 CONTACTS plus leading retail stores like LensCrafters[®], Sears OpticalSM, Target Optical[®], JCPenney[®] Optical and most Pearle Vision[®] locations — these stores offer evening and weekend hours.
- **Value-added savings[§]** — 15% to 40% off unlimited purchases of most extra pairs of eyewear, conventional contact lenses, lens treatments and more — even after you've used all of your covered benefits.

	Benefit frequency	Cost Share
Eye exam (with dilation as needed)	Once every 12 months	\$20 copay
Standard plastic (CR39) lenses[‡]	Once every 24 months	
Single vision		\$20 copay
Bifocal		\$20 copay
Trifocal		\$20 copay
Contact lenses:	Once every 24 months	
Elective (conventional and disposable)		\$80 allowance
Non-elective		Covered in full
Frames	Once every 24 months	\$130 allowance

[‡] Factory scratch coating is covered at no extra cost. Polycarbonate and Transitions lenses are covered for dependents.

The medical + dental + vision advantage

Coordinating medical, dental and vision plans can result in better care — delivered sooner and at a lower cost. Plus, you enjoy the convenience of having only one ID card and one bill when you purchase all your coverage from Anthem.

* Does not include ACA required pediatric dental essential health benefits coverage.

† Blue View Vision internal data, 2015.

§ Laws in some states may prohibit in-network providers from discounting products and services that are not covered benefits. Individual and Family Health Plan Guide for Colorado

Dental stand-alone plans

	Anthem Dental Family Value (Dependents age 18 and younger)	Anthem Dental Family Value (Adults age 19+)	Anthem Dental Family (Dependents age 18 and younger)	Anthem Dental Family (Adults age 19+)	Anthem Dental Family Enhanced (Dependents age 18 and younger)	Anthem Dental Family Enhanced (Adults age 19+)
	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network
Dental network	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime
Deductible (per person, all services)	\$50	\$50	\$50	\$50	\$25	\$50
Annual Maximum (per person)	None	\$750	None	\$750	None	\$1,000
Annual out-of-pocket limit	\$350 ¹ / None	None	\$350 ¹ / None	None	\$350 ¹ / None	None
Diagnostic and preventive	No waiting period	No waiting period	No waiting period	No waiting period	No waiting period	No waiting period
Cleaning, exams and x-rays	0% / 30% coinsurance	0% / 50% coinsurance	0% / 30% coinsurance	0% / 50% coinsurance	0% / 20% coinsurance	0% / 50% coinsurance
Extra cleaning	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Basic services	No waiting period	6-month waiting period	No waiting period	6-month waiting period	No waiting period	6-month waiting period
Fillings	40% / 50% coinsurance	50% / 75% coinsurance	40% / 50% coinsurance	50% / 75% coinsurance	20% / 40% coinsurance	20% / 60% coinsurance
Brush biopsy	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Complex & major services	No waiting period	Not covered	No waiting period	12-month waiting period	No waiting period ²	12-month waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	50% / 50% coinsurance ³	Not covered	50% / 50% coinsurance ³	70% / 85% coinsurance	20% / 50% coinsurance	50% / 75% coinsurance
Prosthetics (crowns, dentures, bridges)	50% / 50% coinsurance ³	Not covered	50% / 50% coinsurance ³	70% / 85% coinsurance	50% / 50% coinsurance	50% / 75% coinsurance
Medically necessary orthodontia	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	Not covered
Cosmetic orthodontia	Not covered	Not covered	Not covered	Not covered	50% / 50% coinsurance ⁴	Not covered
International emergency dental program	Included	Included	Included	Included	Included	Included
Blue View Vision	Available	Available	Available	Available	Available	Available

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

Please see Dental stand-alone plans footnotes on page 23.

Dental stand-alone plans

	Dental Prime Plan A	Dental Prime Plan B	Dental Prime Plan C
	In-network / Out-of-network	In-network / Out-of-network	In-network / Out-of-network
Dental network	Dental Prime	Dental Prime	Dental Prime
Deductible (per person, all services)	None	\$50	\$50
Annual Maximum (per person)	\$500	\$1,000	\$1,250
Annual out-of-pocket limit	None	None	None
Diagnostic and preventive	No waiting period	No waiting period	No waiting period
Cleaning, exams and x-rays	0% / 0% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance
Extra cleaning	1 extra cleaning per year for those who are pregnant or diabetic	1 extra cleaning per year for those who are pregnant or diabetic	1 extra cleaning per year for those who are pregnant or diabetic
Basic services	Not covered	6-month waiting period	6-month waiting period
Fillings	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
Brush biopsy	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
Complex & major services	Not covered	12-month waiting period	12-month waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	Not covered	50% / 50% coinsurance	50% / 50% coinsurance
Prosthetics (crowns, dentures, bridges)	Not covered	Not covered	50% / 50% coinsurance
Medically necessary orthodontia	Not covered	Not covered	Not covered
Cosmetic orthodontia	Not covered	Not covered	Not covered
International emergency dental program	Included	Included	Included
Blue View Vision	Available	Available	Available

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

Please see Dental stand-alone plans footnotes on page 23.

Dental stand-alone plans footnotes

1 Per child, up to two children.

2 Except 12-month waiting period for **Cosmetic orthodontia**.

3 Coverage for pediatric children does not cover **Periodontics** or **Prosthetic services**.

4 \$1,000 lifetime maximum for **Cosmetic orthodontia**.

There are currently no Dental Prime plan-contracted dentists in Archuleta, Baca, Chaffee, Cheyenne, Crowley, Dolores, Gilpin, Grand, Hinsdale, Jackson, Kiowa, Lake, Mineral, Moffat, Ouray, Phillips, Pitkin, Rio Blanco, Saguache, San Juan, San Miguel, Sedgwick, Washington and Yuma counties.

Out-of-network providers will bill you for amounts over what your plan pays, up to their usual charge. The procedures listed here are a sample of covered service for members. If you need help to figure out the highest amount payable to an out-of-network dentist, call us at the number on your ID card.

Our plans' built-in extras

At Anthem, we want to be more than your health benefits plan — we want to help you meet your day-to-day health and wellness goals. That's why we offer a variety of programs, discounts and tools to support you being your healthy best.

Health and wellness resources

Whether you're looking for one-on-one coaching or pregnancy support, we're here to give you the guidance you need, when you need it — at no extra cost. **Here's how:**



24/7 Nurseline — is staffed with registered nurses who are just a phone call away at any time. Nurses can answer questions about a medical concern or help you choose the right level of care. Plus, you can call the same phone line and listen to hundreds of health topics in the AudioHealth Library.



Care Support — gives you the extra care and support you need for your ongoing or complex health issues. A case manager may call you to see how we can help keep your condition in check and give you information as well as emotional support services.

And don't forget about those regular checkups! Your yearly exams, flu shots and other preventive care services are covered 100% when you visit in-network providers. These services can give you extra support in managing your health or a specific health condition.



MyHealth Advantage — We're always looking for ways to help you live a healthier life and save money. That's why we review your medical and pharmacy history. If we find a way you can improve your health or save money, you'll get a MyHealth Note in the mail.



SpecialOffers@AnthemSM

SpecialOffers@AnthemSM (SpecialOffers) is our member discount program for health- and wellness-related products and services.

Through the program, members can enjoy discounts on:

- Vitamins
- Health and beauty products
- Massage therapy
- LASIK eye surgery
- Eyeglass frames and contact lenses
- Hearing aids and services
- Jenny Craig® and Weight Watchers® weight-loss programs*
- Smoking cessation programs

To view all our SpecialOffers discounts, log in to [anthem.com](https://www.anthem.com) and select **Discounts**.

* WEIGHT WATCHERS and PointsPlus are the registered trademarks of Weight Watchers International, Inc. Trademarks used under license by WeightWatchers.com, Inc.

Enhanced Personal Health Care

Enhanced Personal Health Care (EHPC) is a kind of doctor-patient relationship created just for Anthem members!

We put members in a unique circle of care, making them the central focus of a team approach to their overall health.

Enhanced Personal Health Care — a program that:

- Helps to improve your patient experience with better access to a primary care doctor who cares for the “whole person” and becomes your health care champion and helps you navigate the health care system.
- Gives doctors added support with the right tools and strategies to help strengthen your doctor-patient relationship, so doctors can spend more time with you and coordinate your care with other doctors.

To find out if your primary care doctor is in the EPHC program, go to [anthem.com/findadoctor](https://www.anthem.com/findadoctor). If your doctor is in the program, you'll see Quality Snapshot within the doctor's listing and the EPHC designation (a heart symbol with a plus sign) under Other Certifications.

Together, you and your doctor work to make the best choices for your health care.








Online Tools

From our website and mobile app to cost and quality comparison tools, we want to make sure you have the information you need to make informed health care decisions for you and your family.

Our secure website:

- Get a breakdown of what is and isn't covered by your plan through a benefit summary.
- See your recent claims and coverage details.
- Pay your premium online.
- Estimate your costs before having certain procedures.
- Manage your prescription benefits and search the drug list that applies to your benefit plan.

Our Anthem Anywhere app:

-  Find a doctor, hospital or pharmacy
-  Get a virtual ID card
-  Compare doctor costs and quality
-  Manage prescription benefits
-  View claims

Cost and quality information with Estimate Your Cost

With our Estimate Your Cost tool, you can save time and money by comparing the cost of common procedures at health care facilities in your area. You'll also get to see the quality and safety ratings for those facilities.

* LiveHealth Online is the trade name of the Health Management Corporation.

† Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications.

‡ Depending on your coverage, the cost may be similar to what you would pay for an office visit, considering your benefits, copay or coinsurance.

LiveHealth[®] O N L I N E

Now you can have a private video visit with a doctor or therapist on your smartphone, tablet or computer. LiveHealth Online* is an easy and convenient way to get the care you need from the comfort and privacy of home.

All you have to do is sign up at livehealthonline.com to use it!

- Get medical advice, diagnoses, proper treatment and even prescriptions, 24/7 in about 10 minutes or less
- Quickly address common health problems, like allergies, colds, rashes, fever and more

Now, you can talk to a licensed therapist or psychologist at home. If you're feeling stressed, worried or having a tough time, we're here to help.

- See a therapist in four days or less[†]
- Choose a time that's convenient for you - seven days a week from 7 a.m. to 11 p.m.

Doctors typically charge \$49 or less per visit and therapists usually cost the same as what you'd pay for an office therapy visit, depending on your medical plan.[‡]



Register at anthem.com for
online access.

Once you're a member, register at anthem.com to access your benefits online. And don't forget to download the **Anthem Anywhere** mobile app, so you can manage your benefits at home or on the go.

Ready to enroll? Let's get started.

If you're ready to take the next step and enroll, we're here to help you every step of the way.

To get started, you'll need to have the following information handy:

- 1 **Employer and income details** (for example, pay stubs and W-2 forms) for every member of your household who needs coverage
- 2 **Policy numbers and insurer names** for any current health insurance plans covering members of your household
- 3 **Name of every job-based health insurance plan** for which you or someone in your household is eligible

Then, you can:

- 4 **Call your broker or Anthem representative** to enroll or learn more about our health care plans. Take a look at the application included with this brochure.
- 5 **Visit our website** at [anthem.com](https://www.anthem.com) and apply online.

Generally, plans can be purchased once a year through an open enrollment period. This year, the open enrollment period runs from November 1, 2016 through January 31, 2017. Be sure to enroll by December 15, 2016, to start coverage effective January 1, 2017.

There are special qualifying events that may allow you to change your health coverage outside of the open enrollment period. Check with your broker or Anthem representative to see if you qualify or if you have other questions about open enrollment.

Your broker or Anthem representative can help you enroll. You can also apply online at [anthem.com](https://www.anthem.com).

Simplified payments

You can set up a recurring payment using electronic funds transfer (EFT) or bank draft, which means your premium will automatically be paid from your bank account each month.

You can also use WebPay to make your monthly payments. This payment program allows you to enroll in automatic recurring payments with a Visa or MasterCard debit or credit card.

If you choose to make regular credit card payments, make sure your card's expiration date and other account information stays up to date.

We want you to be satisfied

After you enroll in one of our plans, you'll have access to an *Evidence of Coverage (EOC)* or *Booklet* that explains the terms and conditions of coverage, including exclusions and limitations. You'll have 10 days to examine your *Booklet's* features. If you're not fully satisfied during that time, you may cancel your coverage and your premium will be refunded, minus any claims that were already paid.

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the *Booklet* may be continued in force or discontinued. For more complete details on what's covered and what isn't:

- Review the *Booklet*.
- Call your broker or Anthem representative.
- Go to [anthem.com](https://www.anthem.com).

To view a copy of both a ***Summary of Benefits and Coverage (SBC)*** and the ***CO SBC Supplement***, please visit sbcsbc.anthem.com and select **Member**.

The health plans described in this document aren't eligible for a premium tax credit or subsidy/cost-sharing assistance. The Affordable Care Act (ACA) helps people with low or modest incomes pay for their health insurance with premium tax credit or subsidy. You can only get financial help if you're eligible and you buy your individual health coverage through Connect for Health Colorado.

In compliance with the ACA, the following plan changes may occur annually on January 1:

- Benefits
- Premiums
- Deductibles, copays, coinsurance and out-of-pocket limits

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



Still have questions?

Please reach out to your broker or Anthem representative. If you're stuck and unsure about next steps, we're here to listen and offer advice. We know there's a great plan out there just for you - let us help you find it!

Important legal information

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

Eligibility

You can apply for coverage for yourself or with your family. You must be a resident of the State of Colorado and not entitled to or enrolled in Medicare. Family health coverage includes you, your spouse or domestic partner and any dependent children. Children are covered to the end of the month in which they turn age 26.

Eligibility for a catastrophic plan

You are eligible for this plan if you:

- are under age 30 before the plan's effective date; or
- have received certification from Connect for Health Colorado that you are exempt from the individual mandate because you qualify for a hardship exemption or don't have an affordable coverage option

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and members may change benefit plans at that time.

Special Enrollment and Changes Affecting Eligibility

In addition to open enrollment, an individual can enroll during the special enrollment period. This is a period of time in which eligible individuals or their dependents can enroll after the open enrollment, typically due to an event such as marriage, birth, adoption, or other qualifying events as defined by law.

Depending on the event which triggered the special enrollment period, coverage may be effective as of the date of the qualifying event.

Effective Date of Coverage

The earliest effective date for the annual open enrollment period is the first day of the following calendar year. The actual effective date is determined by the date Anthem receives a complete application with the applicable premium payment.

Managing your care if you need to go to a hospital or get certain medical treatment

If you or a family member need certain types of medical care (for example: surgery, treatment in a doctor's office, physical therapy, etc.), you may want to know more about these programs and terms. They may help you better understand your benefits and how your health plan manages these types of care.

Utilization Review

Utilization review is a program that is part of your health plan. It lets us make sure you're getting the right care at the right time. Our utilization review team, made up of licensed health care professionals such as nurses and doctors, does medical reviews. The team goes over the information your doctor has sent us to see if the requested surgery, treatment or other type of care is medically necessary. The utilization review team checks to make sure the treatment meets certain clinical guidelines set by your health plan. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The utilization review team will let you and your doctor know as soon as possible. Decisions not

to approve are put in writing. The written notice will include information on how to appeal the decision and about your rights to an independent medical review.

We can do medical reviews like this before, during and after a member's treatment. Here's an explanation of each type of review:

The pre-service review (done before you get medical care)

We may do a pre-service review before a member goes to the hospital or has other types of services or treatment. Here are some types of medical treatments that might call for a pre-service review:

- An inpatient hospital visit;
- An outpatient procedure;
- Tests to find the cause of an illness, like magnetic resonance imaging (MRI) and computed tomography (CT) scans;
- Certain types of outpatient therapy
- Durable medical equipment (DME), like wheelchairs, walkers, crutches, hospital beds and more

The concurrent review (done during medical care and recovery)

We do a concurrent review when you are in the hospital or are released and need more care related to the hospital stay. This could mean services or treatment, such as physical therapy or durable medical equipment. The utilization review team looks at the member's medical information at the time of the review to see if the treatment is medically necessary.

The post-service review (done after you get medical care)

We do a post-service review when you have already had surgery or another type of medical care. When the utilization review team learns about the treatment, they look at the medical information the doctor or provider had about you at the time the medical care was given. The team then can see if the treatment was medically necessary.

Case Management

Case management is conducted by a licensed health care professional, who works with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

Precertification

Precertification is the process of getting approval from your health plan before you get services. This process lets you know if we will cover a service, supply, therapy or drug. We approve services that meet our standards for needed and appropriate treatment. The guidelines we use to approve treatment are based on standards of care in medical policies, clinical guidelines and the terms of your plan. As these may change, we review our precertification guidelines regularly. Precertification is a type of pre-service review.

Here's how getting precertification can help you out:

Saving time. Preauthorizing services is a process of verifying, in advance, whether a proposed treatment, service or supply is medically necessary and/or medically appropriate. The doctors in our network ask for prior authorization for our members.

Saving money. Paying only for medically necessary services helps everyone save. Choosing a doctor who's in our network can help you get the most for your health care dollar.

What can you do? Choose an in-network doctor. Talk to your doctor about your conditions and treatment options. Ask your doctor which covered services need prior authorization or call us to ask. The doctor's office will ask for prior authorization for you. Plus, costs are usually lower with an in-network doctor. If you choose an out-of-network provider, be sure to call us to see if you need prior authorization. Out-of-network providers may not do that for you. It is important to understand that not all plans offer out of network coverage, with the exception of emergency or urgent care. Please review the Booklet in order to determine your benefits. Once you're a member, if you have a question about prior authorization, you can call the Member Service number on the back of your ID card.

In-network Providers

In-network providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain covered services from providers located in the State of Colorado; however, the broadest benefits are provided for services obtained from a primary care physician (PCP), specialty care physician (SCP), or other in-network providers.

With our preferred provider organization (PPO) plans, you have the freedom to see any in-network doctor you choose. With our health maintenance organization (HMO) plans, you choose one of our in-network PCPs who helps to coordinate your care. When you need to see other in-network doctors, a referral from your PCP is not required.

Services you obtain from any provider other than a PCP, SCP or another in-network provider are considered an out-of-network service, except for emergency care or urgent care, or as an authorized service if you purchase one of our HMO plans.

Out-of-network Providers

For HMO plans, services will only be covered services if rendered by providers located in the State of Colorado unless:

- The services are for emergency care, urgent care or ambulance services as specified in the Booklet; or
- The services are approved in advance by Anthem.

Covered services which are not obtained from a PCP, SCP or another in-network provider or not an authorized service will be considered a out-of-network service. The only exceptions are emergency care and urgent care. In addition, certain services are not covered unless obtained from an in-network provider; see your Summary of Benefits. Emergency care from an out-of-network provider is based on the allowable charge determined by us. This means that you may be responsible for the difference between what we allow and what the provider chooses to bill.

For our PPO Catastrophic plan, covered services rendered by out-of-network providers are covered, but your share of the costs may be greater.

For services rendered by an out-of-network provider, you are responsible for:

- The difference between the actual charge and the maximum allowed amount plus any deductible and/or copayments/coinsurance;

- Services that are not medically necessary;
- Non-covered services;
- Filing claims;
- Higher cost-sharing amounts

Laws and rights that protect you

As a member, you have rights and responsibilities. You have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. You also have certain rights and responsibilities when receiving your health care. Visit this link to find more information on our website: <http://www.anthem.com/health-insurance/customer-care/faq>.

Limitations

The specific limitations are spelled out in the terms of the particular plan, but some of the more common services limited by these plans are:

- Ambulance services (non-emergency transportation) – \$50,000 per occurrence if an out-of-network provider is used
- Applied behavior analysis for autism
 - From birth through age 8: 550 sessions, 25 minutes in length per year
 - Depending on the law, you may be entitled to exceed these maximums
- Hearing aids – 1 pair every 5 years for members under age 18
- Home health care – 28 hours per week
- Rehabilitative care (outpatient only) - An equal number of therapy visits are available for rehabilitative care (outpatient only)
 - Chiropractic care – 20 visits per member per year
 - Occupational therapy – 20 visits per member per year
 - Physical therapy – 20 visits per member per year
 - Speech therapy – 20 visits per member per year
- Skilled nursing facility – 100 days per year

Exclusions

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

- Acupuncture, regardless of which type of provider performs the service
- Allergy tests and treatment as specified in the Booklet
- Alternative or complementary medicine
- Artificial and mechanical devices
- Breast reduction or augmentation
- Care provided by a member of your family
- Care received in an emergency room that is not emergency care, except as described in the Booklet's exclusions
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services)
- Comfort and/or convenience items
- Corrective eye surgery

- Cosmetic surgery and/or treatment that's primarily intended to improve your appearance
- Custodial ordered care as described in the Booklet's exclusions
- Dental, except as described in the Booklet
- Educational/training services
- Experimental or investigative treatment and any resulting complications
- Feet – surgical treatment
- Foot care - routine
- Nutritional and dietary supplements, over-the-counter drugs, devices or products
- Pharmacy, except as described in the Booklet
- Physical fitness such as health club memberships, exercise equipment, etc.
- Prescriptions for infertility treatment
- Services we determine aren't medically necessary
- Teeth - Congenital Anomaly - treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in the Booklet or as required by law
- Teeth, Jawbone, Gums - treatment of the teeth, jawbone or gums that are required as a result of a medical condition except as expressly required by law or specifically stated in the Booklet as a covered service
- Vein treatment – treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes
- Vision, except as described in the Booklet
- Weight loss programs or treatment of obesity except as mandated
- Workers' compensation

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A high deductible health plan is not a health savings account (HSA). An HSA is a separate arrangement between an individual and a qualified financial institution. To take advantage of tax benefits, an HSA needs to be established. This brochure provides general information only and is not intended to be a substitute for the advice of a qualified tax professional.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint

with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



Get help today!

To learn more, call your broker or Anthem representative. You can also view and compare plans online at [anthem.com](https://www.anthem.com).

If you'd like a paper copy of this information by fax or mail, call your broker or Anthem representative.