Colorado

Anthem

2022 Plan Year Product Guide

Individual and Family
Bronze, Silver, and Catastrophic plans

Open enrollment period runs
November 1, 2021 - January 15, 2022

HEALTH COVERAGE CREATED WITH YOU IN MIND

Experience the Anthem difference

A00604COMENABS 10/21

HEALTH COVERAGE CREATED WITH YOU IN MIND

GIVING YOU REAL CHOICES FOR EVERY MOMENT OF HEALTH

You can feel confident about choosing Individual healthcare coverage from Anthem Blue Cross and Blue Shield. You'll join 43 million Americans[1] who have coverage through an Anthem plan and access to our network of doctors and hospitals — at home and across our country. Enjoy peace of mind with virtual care, preventive care at no extra cost, and a prescription drug plan with convenient home delivery. Our innovative mobile app and digital wellness tools support your physical and emotional well-being. All of this empowers you to make the best decisions for your health.

Choose a health plan that fits your budget

Our plans offer real choices, no matter where you are in your unique health journey. Every Anthem plan comes with $0 preventive care visits, prescription coverage, and predictable out-of-pocket costs, so it's easier to stay on budget and on top of your health. If cost is a concern, you may be able to lower your monthly premium with financial help through the American Rescue Plan Act. **In fact, 9 out of 10 individual members will receive financial help for health coverage.**[2]

Find information and connect to care with Sydney Health℠

The Sydney Health mobile app makes healthcare easier. With 24/7 access to your health plan information, you can check your benefits, find costs for care, access virtual care through Symptom Checker and Virtual Text Visits, and set personalized action plans to reach your health goals.

Talk to a doctor or therapist wherever you are

Seeing a doctor shouldn't be complicated. Our virtual care tool offers you a smarter, simpler way to access care at home or on the go. Board-certified doctors are available 24/7 in both English and Spanish to give expert medical advice, diagnose common health issues, and send prescriptions right to your pharmacy. Licensed therapists are available for virtual mental health visits seven days a week.

Support your whole health

Along with medical coverage, you can take advantage of additional dental or vision benefits that support your whole health. Connecting your care through an Anthem plan gives your doctors and healthcare professionals a better picture of your overall well-being. This can improve your care, which can lead to better health and lower your healthcare costs over time.

Anthem Link: Virtual healthcare designed for today's world

Anthem Link is a new type of healthcare plan that allows you to choose from a variety of virtual and in-person care options, including unlimited primary care physician visits for $0. It provides 24/7 access to personalized care and live agent customer service, lower costs, and more control of your health. Look for plans with Link in the plan name to learn more.

Important information about our 2022 plans

Anthem is pleased to announce that beginning January 1, 2022, Pathway HMO plans will be available for enrollment in the Denver Region (Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson and Park counties). These plans will offer access to a broad network of providers, including the UC Health network of hospitals and physicians.

We're here to help

If you'd like help choosing a health plan, call us at **888-811-2101**, Monday to Friday, 6:30 a.m. to 6:00 p.m. MT. You can also visit **anthem.com** and select **Individual & Family** or contact your health insurance broker.

With an Anthem plan, you can feel more confident about what matters most — your health.

QUICK ACCESS TO BENEFIT CHARTS

To learn more, select this link to view the plan Benefit Charts and important information.

1 Anthem internal data July 2021: https://www.antheminc.com/AboutAnthemInc/index.htm

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

COVERAGE FOR YOUR NEEDS

Medical: preparing for the unexpected

Your health is personal. Your health plan should be personal, too. Our healthcare coverage plans for Individuals and Families are designed to help you wherever you are on your healthcare journey.

We understand that everyone's budget and care needs are different. Whether you use your medical plan for preventive checkups or have regular doctor appointments, you can choose the right plan for your lifestyle. Plus, as a member, you can select great doctors, care centers, and hospitals from our network of providers to help keep you healthy.

Here are three reasons why medical coverage is important:

- **It can help protect your financial security.** Have you ever thought about how much major surgery costs without health insurance? Now, add that to your mortgage or rent and monthly expenses. An unexpected emergency may cost you a lot more than monthly coverage payments.
- **It helps you stay current with checkups**. When you have coverage, you are more likely to use it — for things like scheduling yearly checkups and tests that can catch issues early. Plans even cover preventive care at no extra cost when you see doctors in your plan's network.
- **It's an investment in you.** You insure your home and cars, so it makes sense to do the same for your health. Your well-being is irreplaceable to you and your loved ones.

We want you to have the information you need to make informed choices with Anthem.

View the medical benefit charts.

You can also find this information in the printed kit.

Lower your costs

If you think coverage will be too costly for your budget, you could check to see if you're eligible for a health insurance subsidy. What is a subsidy? It is financial help from the government to pay for your healthcare coverage.

A subsidy, or advanced premium tax credit, lowers your monthly payment. You may also qualify for a plan where you will pay less for your out-of-pocket costs.

To see if you qualify, visit planfinder.connectforhealthco.com.

COVERAGE FOR YOUR NEEDS

Dental and vision: broader coverage for whole health

Essential pediatric dental and vision benefits are included with our medical plans. Both dental and vision care are important to overall health, so we also offer high-quality stand-alone plans to you and your family.

When you add our dental and vision coverage to your medical benefits, you can help your healthcare team connect your care. For example, dentists and eye doctors can see the early signs of many serious illnesses, including diabetes, cancer, and high blood pressure, during routine exams.[1,2]

Learn more about embedded dental and vision benefits.

Learn more about stand-alone dental and vision benefits.

You can also find this information in the printed kit.

Pharmacy: committed to improving health outcomes

Our pharmacy solution, powered by IngenioRx, is aligned with your medical plan to help make healthcare simpler and more convenient for you. With integrated medical and pharmacy data, it's easier to identify any gaps in your care, make you aware of them and help you work toward improved health results.

Plus, IngenioRx comes with these extras to empower you to make smarter healthcare choices:

- Many commonly-used medications at $0 cost to you
- 24/7 access to dedicated pharmacy experts
- Digital features, like pricing a medication, finding a pharmacy, or refilling a prescription
- Up to a 90-day supply of medicine using home delivery or CVS retail pharmacies
- The ability to search for providers, pharmacies, and facilities in your plan

Learn more about pharmacy benefits.

You can also find this information in the printed kit.

1 Mayo Clinic website: Eye exam (accessed January 2020): mayoclinic.org.

2 Academy of General Dentistry, Know Your Teeth website: Warning Signs in the Mouth Can Save Lives (accessed January 2020); knowyourteeth.com.

Supplemental coverage: staying one step ahead

If you experience an accident, hospital stay, or critical illness, supplemental coverage can provide cash benefits to extend your protection beyond your health plan.

Coverage from LifeSecure™ Insurance Company, offered for sale in cooperation with Anthem, includes Personal Accident, Critical Illness, and Hospital Recovery insurance plans to help protect your finances before and after you meet your medical deductible.[1] You can apply for one product or a combination of products for more complete coverage.

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

PREVENTIVE CARE: PRIORITIZING YOUR HEALTH

Regular checkups help your doctor catch problems early, before they become serious and costly.

Our plans cover yearly medical checkups and other medical preventive care at 100% when you see a plan doctor.

DIGITAL TOOLS

Sydney Health app: important health information in one place

The Sydney Health app can make it easier to navigate your healthcare experience. You can access benefit information, Member Services, virtual care, an interactive chat feature, and other resources.

With the Sydney Health app, you can:

- Check benefit information and claim details.
- Compare costs for healthcare services based on your coverage.
- Search for providers and facilities in your plan.
- Connect to virtual care options.
- Access and use your digital ID card.
- Sync your favorite fitness tracker.
- Symptom Assessment Tool for find the best care options.

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

Sydney Health℠ is offered through an arrangement with CareMarket, Inc., a separate company offering mobile application services on behalf of Anthem Blue Cross and Blue Shield. ©2020-2021

Connect to a virtual care provider with Sydney

If you or a covered family member experiences a common health issue, like the flu or allergies, you can quickly see a board-certified doctor for quality care without leaving home.

Sydney can connect you to doctors any time of the day or night. Virtual provider visits with Spanish-speaking doctors are available by appointment, 7 days a week. Using your computer or mobile device, doctors can assess your condition, provide treatment, and even send a prescription to a local pharmacy.[1] **Many plans offer virtual care visits using the Sydney Health app at no cost to you.**[2]

You can also visit with a licensed therapist for stress, anxiety, depression, family issues, and other behavioral health concerns. Psychiatrists are available by appointment when needed.[3]

The Anthem Skill for Alexa: voice activated assistant for your health plan

There's a new way to find the healthcare information you need, when you need it, in the way you want it. The Anthem Skill works through Amazon's Alexa-ready devices (like an Amazon Echo) or on a mobile device using the Amazon Alexa app.[4] The Skill's basic features come at no extra cost and will enable you to:

- Order your member ID card.
- Check your account balances.
- Confirm your deductibles and out-of-pocket maximums.
- Renew, refill, and check the order status of prescriptions.

1 Prescription availability is defined by physician judgment and state regulations. Psychologists or therapists using LiveHealth Online cannot prescribe medications.

2 Virtual care visits, including medical chats and video visits using the Sydney Health app are at no cost to members for most plans. Those enrolled in High-Deductible Health Plans associated with a Health Savings Account and Catastrophic plans must first meet their deductible. Virtual care visits refer to medical chats and/or video consultation, as deemed appropriate by a licensed physician.

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

4 The Anthem Skill may not be available to all members.
Amazon, Alexa, and all related logos are trademarks of Amazon.com, Inc. or its affiliates. Apple and the Apple logo are trademarks of Apple, Inc., registered in the U.S. and other countries and regions. App Store is a service mark of Apple Inc. and the Google Play logo are trademarks of Google LLC.

NEW! Earn rewards for healthy habits

Our Smart Rewards program lets you and your covered spouse or partner earn rewards for completing health and wellness activities. As you complete the activities, your plan is updated[1] and you can redeem the rewards for a digital gift card from a selection of top retailers[2]. Once you complete the redemption on anthem.com or the Sydney app, your digital gift card is delivered to you by email.

WAYS YOU CAN EARN REWARDS	
Visit your doctor in person for an annual wellness or well-woman exam within the first 90 days of when your plan begins	$25
Complete the health assessment	$20

Find Care: find doctors, check on quality ratings and compare costs

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

Find Care also helps you find high-quality local providers in your plan. You can:

- Search for providers near you by name, specialty, or procedure.
- Compare costs for healthcare services and procedures.
- Explore virtual care options.
- Review provider details, such as their specialties, languages spoken, and office locations.

You can access **Find Care** on our website, anthem.com, through the **Sydney Health** app, or on **The Anthem Skill for Alexa**.

1 Once a claim is processed, typically 60 days after the date of service, you'll be able to see confirmation of the reward which can be found on anthem.com or Sydney under My Health Dashboard, My Rewards page.

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

Out-of-state protection: benefits that travel with you

As an Anthem Blue Cross and Blue Shield member, you have access to care across the country through the BlueCard® program and internationally through the Blue Cross Blue Shield Global Core® program. When you are out of Colorado for work, school, or vacation, you shouldn't have to worry about health surprises. That's why our health maintenance organization (HMO) plans cover medically necessary emergency and urgent care in all 50 states and worldwide. If you are away from home and need care right away, you're covered.

SpecialOffers: special member discounts

With SpecialOffers, you can take advantage of our discounts on health-related products and services, like vitamins, weight-loss coaching, contact lenses, and fitness club memberships (available at home or in the gym).* It's another way Anthem wants to help support you and your health goals.

Extra Resources: a little help can go a long way

Anthem offers tools and resources to help simplify and enhance your health journey.

These offerings include:

- **24/7 NurseLine.** Registered nurses answer your health questions by phone, day or night.
- **Care Support.** Case managers offer guidance and support in managing your ongoing or complex health issues.
- **MyHealth Advantage.** We track your claims to see if there are care gaps or ways to save you money. If we find anything, we mail you a personalized, confidential MyHealth Note that you can also access on the Sydney Health app.

* SpecialOffers discounts are subject to change without notice.

TAKE CONTROL OF YOUR HEALTHCARE DOLLARS

A health savings account (HSA) can help you manage and pay for your healthcare expenses, including deductibles, coinsurance, and prescriptions.

Learn more about HSAs

You can also find this information in the printed kit.

UNDERSTANDING PROVIDER NETWORKS

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

Pathway, Pathway Essentials and Mountain Enhanced networks:

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

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

Not all networks are available in all counties.

Network areas of Colorado where plans are available:

Pathway HMO: Offered in all counties.

Pathway Essentials: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, and Park counties.

Mountain Enhanced: Archuleta, Eagle, La Plata, Mesa, Moffat, Montezuma, Rio Blanco, Routt, and Summit counties.

View our county network coverage map.

You can also find this information in the printed kit.

FIND OUT IF YOUR DOCTOR IS PART OF ANTHEM'S NETWORK

You can follow these steps to check:*

1. Go to **anthem.com** and choose **Find Care**.
2. Scroll to and select *Guest*.
3. Under *What type of care are you searching for?,* choose **Medical**.
4. Select the state you want to search in.
5. Under *What type of plan do you want to search with?*, choose **Medical (Individuals and Families).**
6. Under *Select a plan/network*, pick from the list and choose your selected plan.
7. Select **Continue**.
8. Enter your city, county or zip code (this field is required).
9. Make a selection under **Search by Care Provider**.

* We strive to ensure our provider lists are as accurate as possible. It is important to confirm if a provider is in your plan. You can do this by calling Member Services or the provider.

DECODING ACA METAL LEVELS

We're here to help you understand your plan options, so you can make the best decision for your needs. Consider the coming year and whether you or someone in your family may require:

- Preventive care, like routine checkups, screenings, and lab tests.
- Condition management for an ongoing health problem.
- Access to therapy after an injury.
- Transitional/support services after a major surgery.

To learn more, please look at the chart below:

LEVEL	PREMIUM	DEDUCTIBLE	GOOD FIT IF YOU NEED:
BRONZE	$	$$$$	Basic coverage for checkups and preventive care
SILVER	$$	$$$	Coverage for the basics and have a condition or upcoming procedure

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

GLOSSARY OF TERMS: PLAIN AND SIMPLE

- **Coinsurance:** This is your percentage of cost each time you access care, once your deductible has been paid.
- **Copay:** This is a set dollar amount you pay for covered services, such as doctor visits.
- **Deductible:** This is the set dollar amount you must pay before your plan starts to pay most covered health services. In-network covered preventive services do not require a deductible. Your deductible applies to the calendar year (January 1 through December 31), even if your effective date (the date coverage begins) is later than January 1.
- **Drug tiers:** Drugs on a drug list or formulary are typically arranged in tiers. Your cost depends on which tier your drug is in.
- **In-network coverage:** When you go to a doctor, hospital, or other provider that accepts a health insurance plan and has agreed to a negotiated amount for their services, this is considered in-network coverage. In-network providers are also called participating providers.
- **Network:** A network is made up of doctors, hospitals, pharmacies, and other providers that offer medical care at negotiated rates to health plan members.
- **Out-of-network coverage:** When you go to a doctor, hospital, or other provider that does not take your health insurance plan and does not agree to a negotiated amount for their services, this is considered out-of-network coverage. In these instances, you will be responsible for paying the provider's charges in full, except for emergency and urgent care, or when a service is preapproved.
- **Out-of-pocket maximum:** This is the maximum amount you pay out of your pocket for covered health services each year. Once you reach that limit, which varies by plan, we cover the rest up to the maximum allowed amount. In-network providers accept Anthem's maximum allowed amount as their charge.
- **Plan name:** The plan name and contract code are found on the first row of medical plan charts. Look for this when you're applying for a plan. The contract code is in parentheses after the plan name: “(WXYZ).”
- **Premium:** This is the amount of money you pay monthly to your insurance company to keep your health plan active. You cannot apply what you pay for your premium toward your deductible.
- **Preventive care:** These are medical services, like checkups, screenings, and vaccines. They help you avoid illness or catch problems early. Preventive care is covered at $0 when you visit a provider in your plan network.

SUMMARY OF BENEFITS AND SERVICES

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations, and terms under which the Certificate of Coverage (Coverage) may be continued in force or discontinued. To see complete details on what is covered and what is not:

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

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

IN COMPLIANCE WITH THE AFFORDABLE CARE ACT (ACA), THE FOLLOWING PLAN CHANGES MAY OCCUR ANNUALLY ON JANUARY 1:

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

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

THE POWER OF BLUE

We are proud that 1 in 3 Americans carries a Blue-branded card, which is accepted by many healthcare providers across the country.*

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

Anthem

EXPERIENCE THE ANTHEM DIFFERENCE

We understand that choosing the right care is a big decision. Our health plans were created with budget and choice in mind. We're here to help you understand your benefit options and put your care first.

To see how the Anthem difference can help you:

- Call us at 888-811-2101, 6:30 a.m. to 6:00 p.m. MT or your broker
- Visit **anthem.com**, select **Individual and Family**, and apply online
- You can also take a look at the application included with this brochure

You can buy healthcare plans once a year during open enrollment. For 2022, this period runs from **November 1, 2021 - January 15, 2022**. Dates may change and vary by state.

We know that sometimes big life events happen and you may need to make plan changes outside the open enrollment period. To see if your life event qualifies for a plan change, please call us at the number above or contact your broker.

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

HERE EVERY STEP OF THE WAY

Let us help you find a plan that meets your needs. Call us at 888-811-2101, 6:30 a.m. to 6:00 p.m. MT or contact your broker. You can also go to **anthem.com** and select **Individual and Family**.

A00604COMENABS 10/21

Colorado

Anthem

2022 Plan Year Benefit Charts

Individual and Family
Bronze, Silver, and Catastrophic plans

Open enrollment period runs
November 1, 2021 - January 15, 2022

HEALTH COVERAGE CREATED WITH YOU IN MIND

Experience the Anthem difference

A00606COMENABS 10/21

PLAN BENEFIT CHARTS

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

Not all network plans may be available in all areas. To make sure your selected plan is available in your county, view our county network coverage map here. You can also find this information in the printed kit.

Plan name	Anthem Bronze Mountain Enhanced HMO 5650 Rx Copay (65L8)	Anthem Bronze Mountain Enhanced HMO 6000 (65L5)	Anthem Bronze Mountain Enhanced HMO 7050 for HSA (65L2)	Anthem Bronze Mountain Enhanced HMO 8700 (65LL)	Anthem Bronze Pathway HMO 5650 Rx Copay (65L9)	Anthem Bronze Pathway HMO 6000 (65L4)	Anthem Bronze Pathway HMO 7050 for HSA (65L3)
Network name	Mountain Enhanced	Mountain Enhanced	Mountain Enhanced	Mountain Enhanced	Pathway	Pathway	Pathway
Plan includes out-of-network coverage?	No	No	No	No	No	No	No
Individual deductible	$5,650	$6,000	$7,050	$8,700	$5,650	$6,000	$7,050
Individual out-of-pocket maximum	$8,700	$8,700	$7,050	$8,700	$8,700	$8,700	$7,050
Coinsurance (percentage may vary for certain covered services)	40%	30%	0%	0%	40%	30%	0%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office (in person or online) visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$50 copay per visit for the first 2 visits, then deductible and 40% coinsurance	$45 copay per visit for the first 3 visits, then deductible and 30% coinsurance	Deductible, then covered in full	$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance	$50 copay per visit for the first 2 visits, then deductible and 40% coinsurance	$45 copay per visit for the first 3 visits, then deductible and 30% coinsurance	Deductible, then covered in full
Virtual visit from our online provider: LiveHealth Online	$0 copay	$0 copay	Deductible, then covered in full	$0 copay	$0 copay	$0 copay	Deductible, then covered in full
Medical chat and virtual visit for primary care from our online provider: K Health	0% coinsurance	0% coinsurance	Deductible, then covered in full	0% coinsurance	0% coinsurance	0% coinsurance	Deductible, then covered in full
Office and online visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $250 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then $250 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then covered in full
Urgent care (Other office services may be subject to deductible and plan coinsurance)	$50 copay	$50 copay	Deductible, then covered in full	Deductible, then covered in full	$50 copay	$50 copay	Deductible, then covered in full
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then $200 copay and 40% coinsurance	Deductible, then $200 copay and 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then $200 copay and 40% coinsurance	Deductible, then $200 copay and 30% coinsurance	Deductible, then covered in full
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then covered in full
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1: Level 1 / Level 2	$30 copay / $40 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	$30 copay / $40 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2: Level 1 / Level 2	$75 copay / $85 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	$75 copay / $85 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3: Level 1 / Level 2	$150 copay / $160 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	$150 copay / $160 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	$650 copay / $660 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	$650 copay / $660 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance
Physical and occupational therapy[2] (limits apply)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full
Speech therapy[2] (limits apply)	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full

Please see Medical plans footnotes on page 5.

Individual and Family Benefit Charts for Colorado anthem.com |

PLAN BENEFIT CHARTS

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

Not all network plans may be available in all areas. To make sure your selected plan is available in your county, view our county network coverage map here. You can also find this information in the printed kit.

Plan name	Anthem Bronze Pathway HMO 8700 (65LG)	Anthem Bronze Pathway Essentials HMO 5650 Rx Copay (65L6)	Anthem Bronze Pathway Essentials HMO 6000 (65L7)	Anthem Bronze Pathway Essentials HMO 7050 for HSA (65LA)	Anthem Bronze Pathway Essentials HMO 8700 (65LJ)	Anthem Link Silver Mountain Enhanced HMO 2500 30% (65KM)	Anthem Silver Mountain Enhanced HMO 3500 Rx Copay 15% (65KQ)
Network name	Pathway	Pathway Essentials	Pathway Essentials	Pathway Essentials	Pathway Essentials	Mountain Enhanced	Mountain Enhanced
Plan includes out-of-network coverage?	No	No	No	No	No	No	No
Individual deductible	$8,700	$5,650	$6,000	$7,050	$8,700	$2,500	$3,500
Individual out-of-pocket maximum	$8,700	$8,700	$8,700	$7,050	$8,700	$8,700	$8,700
Coinsurance (percentage may vary for certain covered services)	0%	40%	30%	0%	0%	30%	15%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office (in person or online) visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance	$50 copay per visit for the first 2 visits, then deductible and 40% coinsurance	$45 copay per visit for the first 3 visits, then deductible and 30% coinsurance	Deductible, then covered in full	$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance	$0 copay	$45 copay per visit for the first 3 visits, then deductible and 15% coinsurance
Virtual visit from our online provider: LiveHealth Online	$0 copay	$0 copay	$0 copay	Deductible, then covered in full	$0 copay	$0 copay	$0 copay
Medical chat and virtual visit for primary care from our online provider: K Health	0% coinsurance	0% coinsurance	0% coinsurance	Deductible, then covered in full	0% coinsurance	0% coinsurance	0% coinsurance
Office and online visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 30% coinsurance	Deductible, then 15% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 30% coinsurance	Deductible, then 15% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then covered in full	Deductible, then $250 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then $250 copay and 30% coinsurance	Deductible, then $500 copay and 15% coinsurance
Urgent care (Other office services may be subject to deductible and plan coinsurance)	Deductible, then covered in full	$50 copay	$50 copay	Deductible, then covered in full	Deductible, then covered in full	$50 copay	$50 copay
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then covered in full	Deductible, then $200 copay and 40% coinsurance	Deductible, then $200 copay and 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then $250 copay and 30% coinsurance	Deductible, then $500 copay and 15% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then covered in full	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then $500 copay and 30% coinsurance	Deductible, then $500 copay and 30% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 30% coinsurance	Deductible, then 15% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: No deductible
Retail pharmacy tier 1: Level 1 / Level 2	0% coinsurance / 0% coinsurance	$30 copay / $40 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	30% coinsurance / 40% coinsurance	$5 copay / $15 copay
Retail pharmacy tier 2: Level 1 / Level 2	0% coinsurance / 0% coinsurance	$75 copay / $85 copay	30% coinsurance / 40% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	30% coinsurance / 40% coinsurance	$50 copay / $60 copay
Retail pharmacy tier 3: Level 1 / Level 2	0% coinsurance / 0% coinsurance	$150 copay / $160 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	30% coinsurance / 50% coinsurance	$80 copay / $90 copay
Retail pharmacy tier 4: Level 1 / Level 2	0% coinsurance / 0% coinsurance	$650 copay / $660 copay	30% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance	30% coinsurance / 50% coinsurance	$650 copay / $650 copay
Physical and occupational therapy[2] (limits apply)	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 30% coinsurance	Deductible, then 15% coinsurance
Speech therapy[2] (limits apply)	Deductible, then covered in full	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then covered in full	Deductible, then covered in full	Deductible, then 30% coinsurance	Deductible, then 15% coinsurance

Please see Medical plans footnotes on page 5.

Individual and Family Benefit Charts for Colorado

PLAN BENEFIT CHARTS

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

Not all network plans may be available in all areas. To make sure your selected plan is available in your county, view our county network coverage map here. You can also find this information in the printed kit.

Plan name	Anthem Silver Mountain Enhanced HMO 5000 35% (65KT)	Anthem Silver Mountain Enhanced HMO 6500 Rx Copay 40% (65KF)	Anthem Link Silver Pathway HMO 2500 30% (65KL)	Anthem Silver Pathway HMO 3500 Rx Copay 15% (65KP)	Anthem Silver Pathway HMO 5000 35% (65KS)	Anthem Silver Pathway HMO 6500 Rx Copay 40% (65KE)	Anthem Link Silver Pathway Essentials HMO 2500 30% (65KN)
Network name	Mountain Enhanced	Mountain Enhanced	Pathway	Pathway	Pathway	Pathway	Pathway Essentials
Plan includes out-of-network coverage?	No	No	No	No	No	No	No
Individual deductible	$5,000	$6,500	$2,500	$3,500	$5,000	$6,500	$2,500
Individual out-of-pocket maximum	$8,700	$8,000	$8,700	$8,700	$8,700	$8,000	$8,700
Coinsurance (percentage may vary for certain covered services)	35%	40%	30%	15%	35%	40%	30%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office (in person or online) visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$35 copay	$40 copay	$0 copay	$45 copay per visit for the first 3 visits, then deductible and 15% coinsurance	$35 copay	$40 copay	$0 copay
Virtual visit from our online provider: LiveHealth Online	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay	$0 copay
Medical chat and virtual visit for primary care from our online provider: K Health	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance
Office and online visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 35% coinsurance	Deductible, then $500 copay and 50% coinsurance	Deductible, then $250 copay and 30% coinsurance	Deductible, then $500 copay and 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then $500 copay and 50% coinsurance	Deductible, then $250 copay and 30% coinsurance
Urgent care (Other office services may be subject to deductible and plan coinsurance)	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay	$50 copay
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 35% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then $250 copay and 30% coinsurance	Deductible, then $500 copay and 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then $250 copay and 30% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 35% coinsurance	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then 35% coinsurance	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then $500 copay and 30% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1: Level 1 / Level 2	$5 copay / $15 copay	$5 copay / $15 copay	30% coinsurance / 40% coinsurance	$5 copay / $15 copay	$5 copay / $15 copay	$5 copay / $15 copay	30% coinsurance / 40% coinsurance
Retail pharmacy tier 2: Level 1 / Level 2	$40 copay / $50 copay	$40 copay / $50 copay	30% coinsurance / 40% coinsurance	$50 copay / $60 copay	$40 copay / $50 copay	$40 copay / $50 copay	30% coinsurance / 40% coinsurance
Retail pharmacy tier 3: Level 1 / Level 2	35% coinsurance / 50% coinsurance	$80 copay / $90 copay	30% coinsurance / 50% coinsurance	$80 copay / $90 copay	35% coinsurance / 50% coinsurance	$80 copay / $90 copay	30% coinsurance / 50% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	50% coinsurance / 50% coinsurance	$650 copay / $660 copay	30% coinsurance / 50% coinsurance	$650 copay / $650 copay	50% coinsurance / 50% coinsurance	$650 copay / $660 copay	30% coinsurance / 50% coinsurance
Physical and occupational therapy[2] (limits apply)	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance
Speech therapy[2] (limits apply)	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance

Please see Medical plans footnotes on page 5.

Individual and Family Benefit Charts for Colorado anthem.com |

PLAN BENEFIT CHARTS

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

Not all network plans may be available in all areas. To make sure your selected plan is available in your county, view our county network coverage map here. You can also find this information in the printed kit.

Plan name	Anthem Silver Pathway Essentials HMO 3500 Rx Copay 15% (65KR)	Anthem Silver Pathway Essentials HMO 5000 35% (65KD)	Anthem Silver Pathway Essentials HMO 6500 Rx Copay 40% (65KG)	Anthem Catastrophic Pathway HMO 8700 (65L0)	Anthem Catastrophic Pathway Essentials HMO 8700 (65KY)
Network name	Pathway Essentials	Pathway Essentials	Pathway Essentials	Pathway	Pathway Essentials
Plan includes out-of-network coverage?	No	No	No	No	No
Individual deductible	$3,500	$5,000	$6,500	$8,700	$8,700
Individual out-of-pocket maximum	$8,700	$8,700	$8,000	$8,700	$8,700
Coinsurance (percentage may vary for certain covered services)	15%	35%	40%	0%	0%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office (in person or online) visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$45 copay per visit for the first 3 visits, then deductible and 15% coinsurance	$35 copay	$40 copay	$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
Virtual visit from our online provider: LiveHealth Online	$0 copay	$0 copay	$0 copay	Deductible, then covered in full	Deductible, then covered in full
Medical chat and virtual visit for primary care from our online provider: K Health	0% coinsurance	0% coinsurance	0% coinsurance	Deductible, then covered in full	Deductible, then covered in full
Office and online visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then covered in full	Deductible, then covered in full
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then covered in full	Deductible, then covered in full
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $500 copay and 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then $500 copay and 50% coinsurance	Deductible, then covered in full	Deductible, then covered in full
Urgent care (Other office services may be subject to deductible and plan coinsurance)	$50 copay	$50 copay	$50 copay	Deductible, then covered in full	Deductible, then covered in full
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then $500 copay and 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then covered in full	Deductible, then covered in full
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then $500 copay and 30% coinsurance	Deductible, then 35% coinsurance	Deductible, then $1,000 copay and 40% coinsurance	Deductible, then covered in full	Deductible, then covered in full
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then covered in full	Deductible, then covered in full
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: No deductible	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1: Level 1 / Level 2	$5 copay / $15 copay	$5 copay / $15 copay	$5 copay / $15 copay	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2: Level 1 / Level 2	$50 copay / $60 copay	$40 copay / $50 copay	$40 copay / $50 copay	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3: Level 1 / Level 2	$80 copay / $90 copay	35% coinsurance / 50% coinsurance	$80 copay / $90 copay	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	$650 copay / $650 copay	50% coinsurance / 50% coinsurance	$650 copay / $660 copay	0% coinsurance / 0% coinsurance	0% coinsurance / 0% coinsurance
Physical and occupational therapy[2] (limits apply)	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then covered in full	Deductible, then covered in full
Speech therapy[2] (limits apply)	Deductible, then 15% coinsurance	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then covered in full	Deductible, then covered in full

Please see Medical plans footnotes on page 5.

Individual and Family Benefit Charts for Colorado anthem.com |

MEDICAL PLANS FOOTNOTES

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

2 **Physical, occupational, or speech outpatient therapy** is limited to up to 20 visits for each therapy per year for **rehabilitation services**. A separate 20-visit limit for each therapy per year applies to **habilitation services**. From birth until the member's 6th birthday, both of these benefits are provided as required by applicable law.

IMPORTANT LEGAL INFORMATION

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

Eligibility

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

Eligibility for a catastrophic plan

You are eligible for this plan if you:

- are also under age 30 before the plan's effective date; or
- have received certification from Healthcare.gov that you qualify for a hardship exemption or do not have an affordable coverage option

Open enrollment

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

Special enrollment and changes affecting eligibility

In addition to open enrollment, an individual can enroll during the special enrollment period. This is a period of time in which eligible individuals or their dependents can enroll after the open enrollment, typically due to an event such as marriage, birth, adoption, or other qualifying events as defined by law. You or your spouse may qualify if one of you experiences a decrease in household income that results in eligibility for financial assistance through the government in paying your premium, provided you or your spouse had Minimum Essential Coverage for one or more days in the 60 days prior to the date of the financial change.

Effective date of coverage

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

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

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

Utilization review

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

Reviewing where services are provided

A service must be medically necessary to be a covered service. The utilization review may include a review of the level of care, type of setting or place of service where services can be safely given to you. If services are given in a higher level of care or cost setting when they could be safely given in a lower level place of care or cost setting, they will not be determined to be medically necessary. The service(s), in that case, are being denied based on the review of where they are provided. When this happens the service(s) can be requested again in another setting or place of care and will be reviewed again for medical necessity. At times, a different type of provider or facility may need to be used in order for the service to be considered medically necessary.

Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a hospital but may be approved if provided on an outpatient basis in a hospital setting.

- A service may be denied on an outpatient basis if taking place in a hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical center/facility, or in a physician's office.
- A service may be denied at a skilled nursing facility but may be approved in a home setting.

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

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

We may do a pre-service review before a member goes to the hospital or has other types of services or treatment.

The concurrent review (done during medical care and recovery)

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

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

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

Case management

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

Precertification

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

Here is how requesting precertification can help you:

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

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

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

In-network providers

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

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

Out-of-network providers

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

- The services are for emergency care, urgent care or ambulance services related to an emergency for transportation to a hospital or urgent care services received at an urgent care center, as specified in the Certificate; or

- 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 or ambulance services related to an emergency for transportation to a hospital or urgent care services received at an urgent care center. In addition, certain services are not covered unless obtained from an in-network provider; see your Summary of Benefits. Emergency care from an out-of-network provider is based on the allowable charge determined by us. This means that you may be responsible for the difference between what we allow and what the provider chooses to bill.

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

Exclusions

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

- Acupuncture, regardless of which type of provider performs the service
- Alternative or complementary medicine
- Artificial and mechanical devices
- Breast reduction or augmentation
- Care provided by a member of your family
- Care received in an emergency room that is not emergency care, except as described in the Certificate's exclusions
- Charges incurred prior to the effective date of coverage or after the termination date of coverage

- Charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services)
- Comfort and/or convenience items
- Compound drugs except as stated in your Certificate
- Consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications
- Corrective eye surgery
- Cosmetic surgery and/or treatment that's primarily intended to improve your appearance
- Custodial ordered care as described in the Certificate's exclusions (this exclusion does not apply to hospice care)
- Dental, except as described in the Certificate
- Educational/training services
- Experimental or investigative treatment and any resulting complications
- Feet – surgical treatment
- Foot care – routine
- In-vitro fertilization (IVF) as described in the Certificate's exclusions
- Nutritional and dietary supplements, over-the-counter drugs, devices or products
- Physical fitness such as health club memberships, exercise equipment, etc.
- Prescriptions for infertility treatment, except where coverage is specifically required by law.
- Services we determine are not medically necessary
- Teeth – congenital anomaly treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in the Certificate or as required by law
- Teeth, jawbone, gums – treatment of the teeth, jawbone or gums that are required as a result of a medical condition except as expressly required by law or specifically stated in the Certificate as a covered service
- Vein treatment – treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes
- Vision, except as described in the Certificate
- Weight loss programs/surgery or treatment of obesity, as specified in the Certificate
- Workers' compensation

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

It is important we treat you fairly

That is why we follow federal civil rights laws in our health programs and activities. We do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language is not English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

FIND HELP IN YOUR LANGUAGE

If you're curious to know what all this says, here is the English version:

If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (1-855-383-7249). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number listed above.

Spanish

Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (1-855-383-7249). (TTY/TDD: 711)

Amharic

ይህንን ሰነድ ለመረዳት በአማራጭ ቋንቋ እርዳታ ማግኘት ከፈለጉ፣ የአባል አገልግለቶች ቁጥርን (1-855-383-7249) **በመደወል ያለምንም ክፍያ ማግኘት ይችላሉ።** (TTY/TDD: 711)

Arabic

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

Bassa

Ɔ jŭ ké m̀ dyi gbo-kpá-kpá mɔ́ ɓɛ́ m̀ ké céè-dɛ̀ nìà kɛ múin wɔ́ ɖé bãà-wɛ̃̄n wùɖù ɖò mú nǐ, m̀ ɓɛ̃́n ɔ zɔ̀ɔ̀ dyìin ɖé Mɛ́ɓà jè gbo-gmɔ̀ Kpòɛ̀ nɔ̀ɓà nìà kɛ <1-855-383-7249> ɖá ɖá mú. M̀ se wǐɖǐ kàkò ɖò pɛ̃́n mu. (TTY/TDD: 711)

Chinese

如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(1-855-383-7249)請求免費協助。(TTY/TDD: 711)

Farsi

در صورتی که برای درک این سند به زبانی دیگر نیازمند کمک هستید،
می‌توانید بدون هیچ هزینه اضافی این را درخواست کنید. برای این کار با
مرکز خدمات اعضاء به شماره 1-855-383-7249 تماس بگیرید، (TTY/TDD: 711)

French

Si vous avez besoin d’aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 1-855-383-7249. (TTY/TDD: 711)

German

Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (1-855-383-7249). (TTY/TDD: 711)

Igbo

Ọ bụrụ na ị chọrọ enyemaka iji ghọta dọkụmentị a n’asụsụ dị iche, ị nwere ike ịrịọ ya na akwụghị ụgwọ ọ bụla ọzọ site na ịkpọ nọmba Ọrụ Onye Otu (1-855-383-7249). (TTY/TDD: 711)

Japanese

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

Korean

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

FIND HELP IN YOUR LANGUAGE

Nepali

यदि तपाईंलाई यो कागजात कुनै अर्को भाषामा बुझ्न सहायता चाहिएमा, तपाईंले सदस्य सेवा नम्बर (1-855-383-7249) मा कल गरेर कुनै अतिरिक्त खरच बिना यसको लागि अनुरोध गरन सक्नुहुन्छ। (TTY/TDD: 711)

Oromo

Sanada kana afaan kan biroodhaan hubachuuf yoo gargaarsa barbaadde lakkoofsa bilbilaa tajaajila miseensaa (Member Services) (1-855-383-7249) waraqaa eenyummaa kee irra jiru irratti bilbiluudhaan kaffaltii dabalataa malee gaafachuu dandeessa. (TTY/TDD: 711)

Russian

Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (1-855-383-7249). (TTY/TDD: 711)

Tagalog

Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (1-855-383-7249). (TTY/TDD: 711)

Vietnamese

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

Yoruba

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

Anthem

EXPERIENCE THE ANTHEM DIFFERENCE

Start by:

- Calling us at 888-811-2101, 6:30 a.m. to 6:00 p.m. MT or your broker
- Visiting **anthem.com**, select **Individual and Family**, and applying online
- Taking a look at the application included with this brochure

You can buy healthcare plans once a year during open enrollment. For 2022, this period runs from **November 1, 2021 - January 15, 2022**. Dates may change and vary by state.

We know that sometimes big life events happen and you may need to make plan changes outside the open enrollment period. To see if your life event qualifies for a plan change, please call us at the number above or contact your broker.

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

HERE EVERY STEP OF THE WAY

Let us help you find a plan that meets your needs. Call us at 888-811-2101, 6:30 a.m. to 6:00 p.m. MT or contact your broker. You can also go to **anthem.com** and select **Individual and Family**.

A00606COMENABS 10/21

Colorado

2022 Plan Year
Embedded Benefit Charts
Individual and Family

EMBEDDED PEDIATRIC DENTAL AND VISION

Essential benefits included with your ON and OFF Exchange plan

A00350COMENABS 9/21

EMBEDDED PEDIATRIC DENTAL BENEFITS DETAILS

Embedded pediatric dental benefits are included with all of our medical plans for members until the end of the month in which they turn 19. Coverage includes preventive care, fillings and some other major services like medically necessary orthodontia.

- Shared deductible for medical and dental services
- Shared out-of-pocket maximum for medical and dental services

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

1 For medical plans where the deductible equals the out-of-pocket maximum, any services subject to the deductible have coinsurance of 0% after deductible.
2 Orthodontia is usually considered dentally necessary when a child's teeth are misaligned (crooked or not spaced correctly) to the point where they don't work properly. This could cause the child to have trouble speaking or eating. Some examples would be (1) if a child can't bite into an apple because they can't close their front teeth together or (2) if a child bites into the gum tissue of the palate (roof of the mouth) when trying to bite down.

EMBEDDED PEDIATRIC VISION BENEFITS DETAILS

The following vision care services are covered for members until the end of the month in which they turn 19. Coverage may include eye exams, eyeglass lenses, frames, and contact lenses. The benefit period is the calendar year (January 1 through December 31). If you purchase a Catastrophic plan, you must meet your medical deductible before pediatric vision benefits are paid.

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

1 A collection of frames and lenses that can be purchased for a $0 copay (may differ by provider).
2 Benefits for contact lenses are in lieu of the eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period

Copies of Colorado network access plans are available on request from Member Services or can be obtained by going to anthem.com/co/networkaccess.
Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

A00350COMENABS 9/21

Anthem

HEALTHY SMILES. HEALTHY EYES. HEALTHY YOU.

You can help take control of your total health with the right dental and vision coverage.

A00608COMENABS DAT Rev. 09/21

Regular dental checkups are about more than keeping your mouth healthy. They can help dentists identify health conditions like heart disease and diabetes. In fact, over 90% of diseases first show signs and symptoms in the mouth.[1]

In addition, eye exams do more than make sure you can see clearly. Eye doctors are often the first to find signs of chronic health conditions, such as diabetes, high blood pressure, and high cholesterol – all through an eye exam.[2]

That is why we want to make it easier for you to take care of your smile and your eyes — and help catch health issues earlier.

It's easy to find the dental and vision coverage you need to help protect your overall health. You can buy dental and vision plans during open enrollment when you purchase a medical plan. Or you can buy dental and vision plans on their own all year round without having to wait until the next open enrollment.

ANTHEM DENTAL PLANS

When you choose Anthem, you will have access to one of the largest dental networks in the country, so you're sure to find a dental who is close to home or work.

Plus, you will receive 100% coverage for preventive care, like regular dental cleanings, exams, and X-rays, when you go to a dentist in your plan. All plans cover preventive care, with no waiting periods, so those benefits can be used right away. Anthem has strong network discounts - our members save more by visiting one of our network dentists with our 38% average national network discount.[3]

Our Essential Choice PPO dental plans feature higher annual benefit maximums (the amount that your plan will pay for dental care). These plans also allow you to carry over part of your unused benefits to the next year. This means if you do not use all of your dental benefits one year, you could carry part of it over and can double your annual maximum benefit over time.

These plans also feature shorter waiting periods for basic and major services than traditional plans, and our Incentive plan does not have any waiting periods.

We offer a variety of individual and family plan options to fit your needs and budget, including:

Anthem Essential Choice PPO dental plans

Our dental plans — good for individuals or families — give you five options to choose from to help save money on dental care. You can have coverage for popular services, such as teeth whitening, implants, and child orthodontics. All five of these plans cover tooth-colored fillings on back teeth.

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

Anthem Family Dental PPO plan

Our Family Dental PPO plan helps you get the dental care you need to stay healthy and gives you the flexibility to choose any dentist.

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

OUR PLANS HELP LOWER YOUR OUT-OF-POCKET COSTS

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

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

Find a dentist

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

To compare dental plan benefits, see our detailed charts.

ONLINE RESOURCES TO PUT A SMILE ON YOUR FACE

All plans come with online tools to help you better understand your dental health. Once you are a member, log in to anthem.com to use:

Ask a hygienist

You can email questions to licensed dental professionals and receive quick, private, personalized advice at no extra cost.

Dental cost estimator

This tool helps you estimate your costs for dental procedures and services in the ZIP code where you receive care, before you go.

Dental health assessment

After you answer a few questions, you will receive feedback based on those responses to help you keep a healthy smile.

Teledentistry

The TeleDentists® offers virtual dental care, including emergency exams, and can prescribe medications, if needed.

Dental care when you're away from home

If you travel outside of the U.S., you still have access to emergency dental services through the International Emergency Dental Program,[4] which comes with all of our plans. With one call, you can receive help finding an English speaking dentist for your urgent dental care needs. You can even receive help with translation services when you call the dentist's office. Services you receive through this program will not count toward your yearly limit, if your plan has one.

BLUE VIEW VISION PLANS

With Blue View Vision, choose from more than 39,000 eye doctors and other eye care providers at over 28,000 locations.[5]

You can go to an independent eye doctor or popular regional and national stores, such as LensCrafters®, Target Optical®, and most Pearle Vision® locations. Our network is one of the largest in the country, so you will be able to receive your eye care and eyewear just about anywhere.

Plus, you will have access to online retailers 24/7, including Glasses.com, ContactsDirect or 1-800 CONTACTS®.

Plan features

Our plans are designed with your lifestyle in mind and give you options to fit your needs and budget. All Blue View Vision plans have:

- **Coverage for yearly eye exams.**
- **Add-ons at no extra cost,** including factory scratch coating on eyeglass lenses.
- **Discounts for other add-ons,** including Transitions® lenses, premium progressive lenses, and premium antireflective coatings.
- **Value-added savings,**[6] including 15% to 40% off most extra pairs of glasses, contact lenses, lens treatments, specialized lenses, and various accessories — even after you've used all of your covered benefits.
- **Discounts through SpecialOffers@Anthem℠ for LASIK,** plus other products and services that promote better health and well-being.

Standalone plans

If you'd like to buy vision coverage separately from medical and dental, we offer a variety of plan options, including:

Individual and family plans

You can choose from three plans to fit your family's needs and budget:

- Value
- Plus
- Enhanced

You will find the coverage you're looking for with our comprehensive plans that include options to add on the latest lens enhancements for members over age 19. You can choose from five plans:

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

To compare vision plan benefits, see our detailed charts.

Bundled plan

You can add this plan to an Anthem medical or dental plan.

Pediatric vision benefits

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

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

Savings example

When you have a Blue View Vision plan from Anthem, it often pays for itself — and then some.

	RETAIL	MEMBER COPAY	MEMBER PAYS	MEMBER SAVES
Exam	$80	$20	$20	$60
Frame	$130	No copay	$0	$130
Bifocal lenses	$80	$20	$20	$60
Scratch coating	$22	No copay	$0	$22
Progressive premium tier 1	$140	No copay	$85	$55
Polycarbonate lenses	$55	No copay	$40	$15
Antireflective premium tier 2	$100	No copay	$68	$32
Transition lenses	$110	No copay	$75	$35
Total	**$717**			**$409**

Anthem

YOU CAN SIGN UP TODAY FOR OUR DENTAL AND VISION PLANS!

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

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

1 Academy of General Dentistry. Warning Signs in the Mouth Can Save Lives (Accessed June 2020): knowyourteeth.com.
2 Your Sight Matters. 7 Health Problems Eye Exams Can Detect (accessed March 2020): yoursightmatters.com.
3 Anthem Quarterly Network Metric Report.
4 The International Emergency Dental Program is managed by DeCare Dental. DeCare Dental is an independent company offering dental management services to Anthem Blue Cross and Blue Shield.
5 NetMinder data, May 2020.
6 Laws in some states may prohibit in-network providers from discounting products and services that are not covered benefits.

This is only a brief description of some plan terms and benefits. Please refer to your Evidence of Coverage for more complete details, including benefits, limitations and exclusions.

Sydney Health is offered through an arrangement with CareMarket, Inc., a separate company offering mobile application services on behalf of Anthem Blue Cross and Blue Shield.

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of Anthem.

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

Colorado

Anthem

2022 Plan Year Benefit Charts

Individual and Family
Dental and Vision Benefits

For plans effective January 1, 2022

Take control of your total health with the right dental and vision coverage

Get more with Anthem

A0061OCOMENABS DAT 09/21

ANTHEM ESSENTIAL CHOICE PPO PLANS

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

ANTHEM DENTAL FAMILY PPO PLANS

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

BLUE VIEW VISION PLANS

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

	Blue View Vision Bundled		Blue View Vision Enhanced		Blue View Vision Plus		Blue View Vision Value	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Eye exam (with dilation as needed)	$20 copay	$30 Reimbursement	$10 copay	$30 Reimbursement	$10 copay	$30 Reimbursement	$20 copay	$30 Reimbursement
Frequency	Once every 12 months	Once every 12 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses								
Single vision	$20 copay	$25 Reimbursement	$10 copay	$25 Reimbursement	$20 copay	$25 Reimbursement	$20 copay	$25 Reimbursement
Bifocal	$20 copay	$40 Reimbursement	$10 copay	$40 Reimbursement	$20 copay	$40 Reimbursement	$20 copay	$40 Reimbursement
Trifocal	$20 copay	$55 Reimbursement	$10 copay	$55 Reimbursement	$20 copay	$55 Reimbursement	$20 copay	$55 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Lens add-ons								
Factory Scratch	Not covered	Not covered	$0 copay	Not covered	$0 copay	Not covered	Not covered	Not covered
Tint	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Standard anti-reflective coating	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Standard progressive lens *The copay is in addition to bifocal copay.*	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Polycarbonate								
Members under age 19	Not covered	Not covered	$0 copay	Not covered	$0 copay	Not covered	Not covered	Not covered
Members over age 19	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Transitions								
Members under age 18	Not covered	Not covered	$0 copay	Not covered	$0 copay	Not covered	Not covered	Not covered
Members over age 18	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Frames	$130 allowance	$45 Reimbursement	$150 allowance	$45 Reimbursement	$130 allowance	$45 Reimbursement	$130 allowance	$45 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every other calendar year	Once every other calendar year	Once every other calendar year	Once every other calendar year
Contact lenses Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.								
Elective (conventional and disposable)	$80 allowance	$60 Reimbursement	$150 allowance	$60 Reimbursement	$130 allowance	$60 Reimbursement	$80 allowance	$60 Reimbursement
Nonelective	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement
Frequency	Once every 24 months	Once every 24 months	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year

BLUE VIEW VISION PLANS

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

	Blue View Progressive Preferred		Blue View Progressive Select		Blue View Vision Basic		Blue View Vision Premier	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Eye exam (with dilation as needed)	$10 copay	$30 Reimbursement	$10 copay	$30 Reimbursement	$20 copay	$30 Reimbursement	$10 copay	$30 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses								
Single vision	$10 copay	$25 Reimbursement	$20 copay	$25 Reimbursement	$20 copay	$25 Reimbursement	$20 copay	$25 Reimbursement
Bifocal	$10 copay	$40 Reimbursement	$20 copay	$40 Reimbursement	$20 copay	$40 Reimbursement	$20 copay	$40 Reimbursement
Trifocal	$10 copay	$55 Reimbursement	$20 copay	$55 Reimbursement	$20 copay	$55 Reimbursement	$20 copay	$55 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Lens add-ons								
Factory Scratch	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered	$0 copay	Not covered
Tint	$5 copay	Not covered	$5 copay	Not covered	Not covered	Not covered	$5 copay	Not covered
Standard anti-reflective coating	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered	$15 copay	Not covered
Standard progressive lens *The copay is in addition to bifocal copay.*	$40 copay	$40 Reimbursement	$50 copay	$40 Reimbursement	$85 copay	$40 Reimbursement	$85 copay	$40 Reimbursement
Polycarbonate								
Members under age 19	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Members over age 19	$10 copay	Not covered	$10 copay	Not covered	$10 copay	Not covered	$10 copay	Not covered
Transitions								
Members under age 18	$65 copay	Not covered	$65 copay	Not covered	$65 copay	Not covered	$65 copay	Not covered
Members over age 18	$20 copay	Not covered	$20 copay	Not covered	$20 copay	Not covered	$20 copay	Not covered
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Frames	$150 allowance	$45 Reimbursement	$130 allowance	$45 Reimbursement	$150 allowance	$45 Reimbursement	$180 allowance	$45 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year
Contact lenses Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.								
Elective (conventional and disposable)	$150 allowance	$60 Reimbursement	$130 allowance	$60 Reimbursement	$150 allowance	$60 Reimbursement	$180 allowance	$60 Reimbursement
Nonelective	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement	$0 copay	$210 Reimbursement
Frequency	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year	Once every calendar year

BLUE VIEW VISION PLANS

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

	Blue View Vision Ultra	
	In-network	Out-of-network
Eye exam (with dilation as needed)	$10 copay	$30 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Standard plastic (CR39) lenses		
Single vision	$10 copay	$25 Reimbursement
Bifocal	$10 copay	$40 Reimbursement
Trifocal	$10 copay	$55 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Lens add-ons		
Factory Scratch	$0 copay	Not covered
Tint	$5 copay	Not covered
Standard anti-reflective coating	$15 copay	Not covered
Standard progressive lens *The copay is in addition to bifocal copay.*	$75 copay	$40 Reimbursement
Polycarbonate		
Members under age 19	Not covered	Not covered
Members over age 19	$10 copay	Not covered
Transitions		
Members under age 18	$65 copay	Not covered
Members over age 18	$20 copay	Not covered
Frequency	Once every calendar year	Once every calendar year
Frames	$200 allowance	$45 Reimbursement
Frequency	Once every calendar year	Once every calendar year
Contact lenses Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.		
Elective (conventional and disposable)	$200 allowance	$60 Reimbursement
Nonelective	$0 copay	$210 Reimbursement
Frequency	Once every calendar year	Once every calendar year

LIMITS AND EXCLUSIONS

Exclusions - Blue View Vision

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

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

COUNTY NETWORK COVERAGE MAP

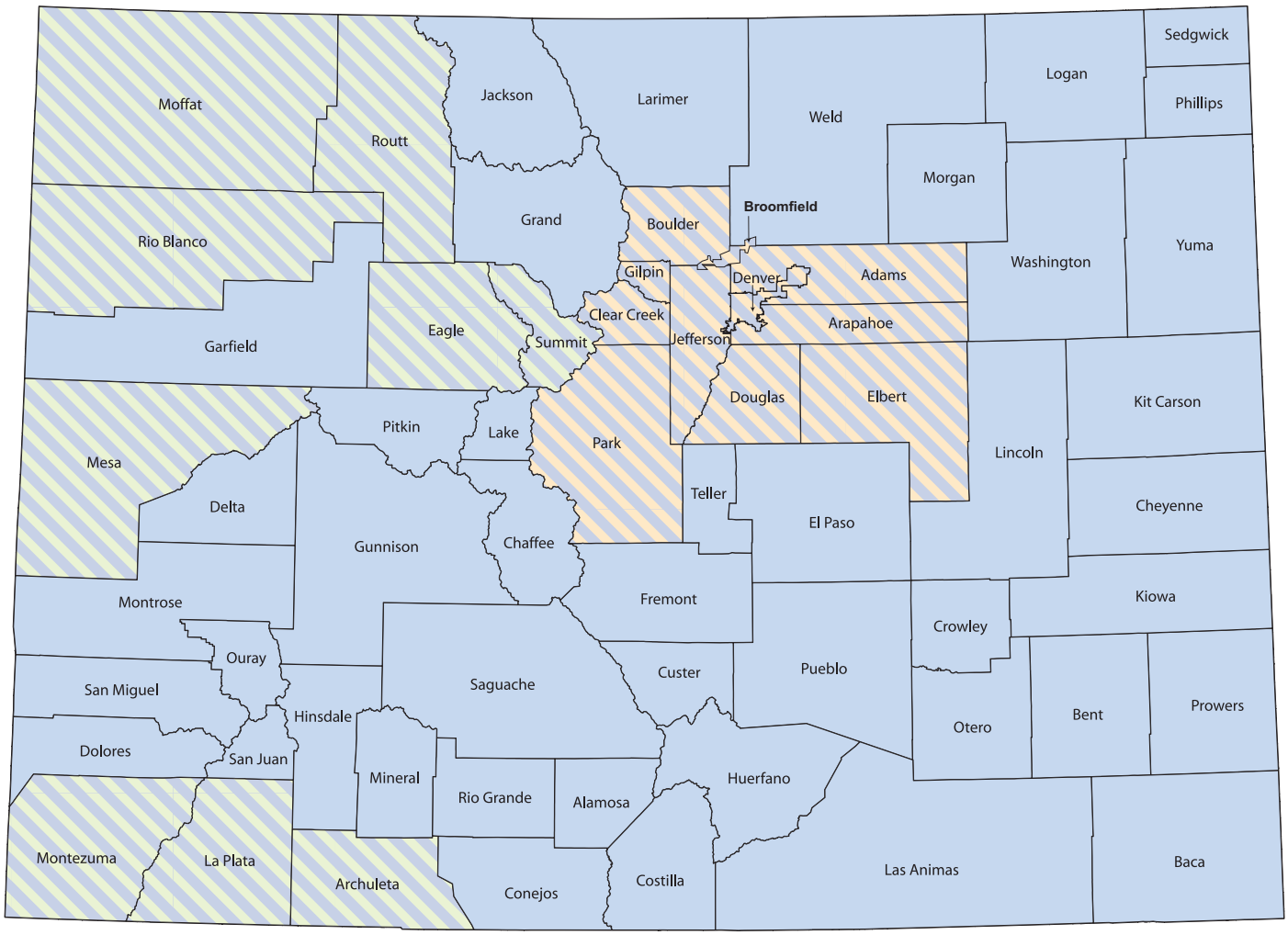
COLORADO

Anthem Blue Cross and Blue Shield Individual Healthcare Coverage Service Area
Effective 1/1/2022

Not all HMO networks are available in all counties. Check this map to see what is available in your area.* Pathway, Pathway Essentials and Mountain Enhanced networks are offered on and off the Marketplace.

= Pathway
= Pathway and Pathway Essentials
= Pathway and Mountain Enhanced

* While we make efforts to ensure that our lists of doctors, hospitals, and other providers are up to date and accurate, providers do leave our networks from time to time, and the listings included on *Find Care* at **anthem.com** do change.



113902COMENABS Rev. 07/21

WAYS AN ANTHEM HSA CAN WORK FOR YOU

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

An Anthem HSA account can help you:

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

REAL-TIME ALERTS FOR YOUR ANTHEM HSA

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

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

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

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

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

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

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

- See your account and claims information.
- Take a photo of a receipt and upload it for reimbursement.
- Manage and send payments from your HSA.
- Find care wherever you are, 24/7.

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

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

Anthem

USING YOUR ANTHEM HSA

Open your HSA account

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

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

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

Receive your welcome letter and debit card

Once your account is open:

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

Transfer HSA funds

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

- **A simpler experience.** With your funds in one place, you will have one login, one statement, one mobile app, one support team, and one debit card.
- **More savings by reducing fees.** By consolidating funds and closing your other account, you eliminate account administration fees from your prior HSA custodian.[3]
- **Easier tax filings.** By having one HSA for the whole year, you will only have one set of tax forms to manage when it comes time to file your taxes.
- **Increased investment opportunity.** By combining your accounts, you have the maximum opportunity to grow your savings for the future.

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

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

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

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

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

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

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

117046COMENABS VPOD BV Rev. 06/21 60969218-135587521

Anthem

2022 Plan Year

Anthem Essential Choice PPO and Dental Family PPO plan rates

INDIVIDUAL DENTAL PREMIUMS IN COLORADO

For policies with effective dates January 1 through December 31, 2022

48438COMENABS DAT 09/21

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

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

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

The child/children rates shown in the charts below are defined as dependent children ages 0-18. Any enrollees age 19 and over use the adult rates, including dependent children over the age of 18. For a family, each adult (including dependent children ages 21-26) are rated first, and then up to the three eldest children ages 0-20. You will not be charged premiums for more than three children between the age of 0-20, even if there are more children covered by the plan.

Note that the charts below provide pricing for many of the most common family units. For other combinations, please talk to your broker or sales representative.

Anthem Essential Choice PPO Dental Plan monthly payments

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

Anthem Dental Family Value monthly payments

One adult	$9.85
One child	$13.84
One adult + one child	$23.69
One adult + two children	$37.53
One adult + three or more children	$51.37
Two adults + one child	$33.54
Two adults + two children	$47.38
Two adults + three or more children	$61.22

Anthem Dental Family monthly payments

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

Anthem Dental Family Enhanced monthly payments

One adult	$24.61
One child	$24.61
One adult + one child	$49.22
One adult + two children	$73.83
One adult + three or more children	$98.44
Two adults + one child	$73.83
Two adults + two children	$98.44
Two adults + three or more children	$123.05

Blue View Vision℠ monthly payments

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

Individual	$6.64
Individual + one	$11.62
Family	$18.59

Anthem

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

Blue View Vision:
Individual vision premiums for Colorado

For policies with effective dates from January 1 through December 31, 2022

Eye exams are good for more than just checking your vision. They're also an important part of caring for your overall health. Eye doctors can often find signs of conditions such as diabetes, high blood pressure, and high cholesterol. With your Blue View Vision plan, you have options for eye care and prescription eyewear needs. Our network is one of the largest in the country, so you can choose from more than 39,000 eye doctors and other eye care professionals at more than 29,000 locations.* That includes independent eye doctors, and regional or national stores, such as LensCrafters®, Target Optical®, and most Pearle Vision® locations. You will also have 24/7 access to online retailers, including Glasses.com, ContactsDirect or 1-800 CONTACTS®.

Monthly premiums

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

* NetMinder data, May 2020.

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

101790COMENABS DAT 09/21

PRESCRIPTION DRUG BENEFITS WITH YOU IN MIND

YOUR PHARMACY PLAN OFFERS CONVENIENCE AND CHOICE

Your prescription drug benefits through Anthem are designed to help you conveniently receive the medications you need — when you need them — while limiting your out-of-pocket costs.

Covered medications

Your plan provides a list of covered brand-name and generic drugs that can help keep your out-of-pocket costs down. If a drug you take isn't on the list, you have other options. Your share of the cost will depend on what drug list tier a medication is on. Tiers are levels — the lower the tier, the lower your share of the cost. Your plan also covers certain preventive care drugs with no cost share for you.

Ways to fill your prescriptions

There are two convenient ways to fill your prescription medicine:

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

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

* IngenioRx data, 2020.

103306COMENABS DAT BV Rev. 4/21

Anthem

Manage your prescriptions online or on the go

By using the Sydney Health app or logging in to anthem.com you can:

- See the cost for a medication.
- Find pharmacies in your plan.
- Refill or renew a prescription.
- Start or refill a home delivery prescription.
- Track an order and shipping status in real time.

Extra benefits for better choices

Because your pharmacy benefits are connected to your medical plan, you receive:

- 24/7 access to dedicated pharmacy experts.
- Savings on prescription drugs.
- A simpler, seamless experience with one member ID card, one website, and one app.
- Personalized support for chronic health conditions.

TO LEARN ABOUT THE PHARMACY BENEFITS OF YOUR SPECIFIC PLAN, VISIT ANTHEM.COM.
