Our plans fit your plans
Our plans fit the way you live.

In a world that’s constantly changing, one thing’s for certain. You can benefit from the reliability and protection of health coverage. Whether you’re self-employed, need coverage for your family, just left group coverage, or your job doesn’t provide it, Anthem Blue Cross and Blue Shield offers dependable individual health care plans that save you time and make sense for the way you live.

You’re in charge of your health and budget, and our plans help keep it that way. Check out our wide range of benefit options and if you have any questions, we are here to help. Dependable, valuable protection that fits the way you live. Sounds like a plan.

Experience you can rely on

As one of the most trusted names in health coverage, Anthem has been providing health care coverage and security to Colorado residents for many years. We’re committed to simplifying your life and improving your health. In addition, we offer:

- **One of the largest provider networks in Colorado.** With more than 6,500 doctors and more than 80 hospitals throughout the state, chances are your doctor is one of ours.

- **A choice of plans to fit your budget and lifestyle.** No matter where you are in life, we’ve got a plan designed to fit your health coverage needs, as well as your budget.

- **Optional dental and term life insurance.** To enhance your health and financial future, we also offer dental and term life coverage and make it easy to enroll.

- **Coverage that travels with you.** No matter where life takes you, your health coverage goes with you. And the BlueCard® program makes it easy to access providers throughout the country.

Why do you need health care coverage?

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

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

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

**Copayment** (or Copay) is a specific dollar amount you have to pay for certain covered services.

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

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

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

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

**Network coverage**

With our extensive network of providers, chances are that your doctor is already part of our network. And all our network providers have lower rates for our members. You’ll have access to these lower rates (discounts) before and after meeting your deductible.

Our plans also offer out-of-network coverage but you’ll pay less when you choose an in-network provider. For a list of network providers, go to anthem.com and click on “Find a Doctor.”
Why CoreShare makes sense

If you’re looking for a simple plan design with some of our lowest rates, CoreShare could be the plan that’s right for you. CoreShare offers a vast range of deductibles (from $750 – $25,000) and higher cost-sharing helps lower your monthly premiums. CoreShare offers up to $4 million per member in lifetime benefits.

CoreShare Preventive Care

With CoreShare, the following adult preventive screenings are covered before you meet your deductible and at no cost to you: routine mammogram, Pap, PSA and colorectal screenings. The same coverage applies for immunizations for children under age 13. Other adult preventive services are not covered, except as noted in the Certificate.

Prescription Drug Coverage

The cost of prescription drugs can be staggering so CoreShare includes prescription drug coverage to help you manage those costs.

- **Drug Formulary:** This is a special list of prescription drugs the CoreShare plan covers. We’ve negotiated lower prices on these formulary drugs, so you’ll save when your doctor prescribes from the Plan Formulary posted at www.wellpointnextrx.com/Formulary1.

- **Tier 1:** These drugs have the lowest copay and include low-cost or preferred medications. This tier includes lower cost generic and brand-name drugs.

- **Tier 2:** These drugs have a higher copay than those in Tier 1 and include preferred medications that are generally moderate in cost. They include higher cost generic and brand-name drugs.

- **Specialty:** These are typically high-cost, scientifically engineered drugs and are paid at a coinsurance level instead of copay.

CoreShare Plan highlights

This plan can be ideal for individuals who want affordable protection against significant medical expenses.

**Features:**
- A simple plan design with some of our lowest monthly rates
- Higher percentage of member cost sharing in exchange for lower premiums
- Once the deductible is met, we’ll share 50% of the costs at our negotiated rates up to $3,500, then we’ll cover the rest for covered services
- Coverage for prescription drugs

**You should know:**
- This plan has its own Drug Formulary
- Maternity benefits are not included with this plan

If you have questions or want more details about your options, call your Anthem Agent.
## Covered Services

### Doctor's Office Visits

- In-Network: 50% Coinsurance (with $750, $1500, $2500, $3500, $5000, $7500)
- Out-of-Network: 0% Coinsurance (with $10000, $15000, $25000)

### Professional/Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)

- In-Network: 50% Coinsurance (with $750, $1500, $2500, $3500, $5000, $7500)
- Out-of-Network: 0% Coinsurance (with $10000, $15000, $25000)

### Inpatient Services (overnight hospital/facility stays)

- In-Network: 50% Coinsurance PLUS $500 Facility Copay per day up to the first 3 days (with $750, $1500, $2500)
- Out-of-Network: 70% Coinsurance PLUS $500 Facility Copay per admission (with $750, $1500, $2500)

### Outpatient Services (without overnight hospital/facility stays)

- In-Network or Out-of-Network: 50% Coinsurance (with $750, $1500, $2500, $3500, $5000, $7500) or 0% Coinsurance (with $10000, $15000, $25000)

### Emergency Room Services

- In-Network or Out-of-Network: 50% Coinsurance (with $750, $1500, $2500, $3500, $5000, $7500) or 0% Coinsurance (with $10000, $15000, $25000)

### Preventive Care Services

- In-Network or Out-of-Network: Adults: Routine mammogram, Pap, PSA and Colorectal screenings: no cost to member, deductible waived
- Other Adult Preventive Services: not covered, except as specifically noted in the policy
- Children under age 13: immunizations covered at no cost to member, deductible waived

### Maternity

- Not covered

### Additional Covered Benefits

- Includes, but not limited to: Ambulance, Chiropractic Services, Home Health Care, Mental Health, Physical/Occupational Therapy, Urgent Care

### Prescription Drug Coverage

- Tier 1 (Lower cost Generic and Brand-name drugs): $15 Copay
- Tier 2 (Higher cost Generic and Brand-name drugs): $35 Copay
- Specialty: 25% Coinsurance up to a $2,500 Annual Out-of-Pocket Maximum (the most you’ll have to pay), in-network only and in addition to $2,000 annual deductible
- Non-formulary drugs: Not covered, discounts apply

## Plan Lifetime Maximum

Plan pays up to $4 million per member for in-network and out-of-network services combined.

## Your Share of Costs (after deductible, unless waived)

<table>
<thead>
<tr>
<th>Plan</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>50% Coinsurance (with $750, $1500, $2500, $3500, $5000, $7500)</td>
<td>0% Coinsurance (with $10000, $15000, $25000)</td>
</tr>
<tr>
<td>Family</td>
<td>50% Coinsurance (with $750, $1500, $2500, $3500, $5000, $7500)</td>
<td>0% Coinsurance (with $10000, $15000, $25000)</td>
</tr>
</tbody>
</table>

## In-Network Coinsurance

<table>
<thead>
<tr>
<th>Plan</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>50% Coinsurance (with $3500, $5000, $7500)</td>
<td>50% Coinsurance PLUS $200 Facility Copay per admission (with $750, $1500, $2500)</td>
</tr>
<tr>
<td>Family</td>
<td>70% Coinsurance (with $3500, $5000, $7500)</td>
<td>30% Coinsurance (with $10000, $15000, $25000)</td>
</tr>
</tbody>
</table>

## Out-of-Network Coinsurance

<table>
<thead>
<tr>
<th>Plan</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>50% Coinsurance PLUS $500 Facility Copay per day up to the first 3 days (with $750, $1500, $2500)</td>
<td>70% Coinsurance PLUS $200 Facility Copay per admission (with $750, $1500, $2500)</td>
</tr>
<tr>
<td>Family</td>
<td>70% Coinsurance PLUS $500 Facility Copay per day up to the first 3 days (with $750, $1500, $2500)</td>
<td>70% Coinsurance PLUS $200 Facility Copay per admission (with $750, $1500, $2500)</td>
</tr>
</tbody>
</table>

## How family deductibles and family out-of-pocket maximums work

Each family member has an individual deductible and out-of-pocket maximum. Once one family member reaches their individual deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members.

## Calendar Year Deductible

<table>
<thead>
<tr>
<th>Plan</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$750</td>
<td>$750</td>
</tr>
<tr>
<td>Family</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

## Add Your Chosen Deductible to the Amount Below

<table>
<thead>
<tr>
<th>Plan</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$3,500</td>
<td>$3,500</td>
</tr>
<tr>
<td>Family</td>
<td>$15,000</td>
<td>$15,000</td>
</tr>
</tbody>
</table>

## Out-of-Pocket Maximum

<table>
<thead>
<tr>
<th>Plan</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$7,500</td>
<td>$7,500</td>
</tr>
<tr>
<td>Family</td>
<td>$30,000</td>
<td>$30,000</td>
</tr>
</tbody>
</table>

## Retail and Mail Order Drugs on the Plan Formulary

- Non-formulary drugs: Not covered, discounts apply
- In-network only and in addition to $2,000 annual deductible
- Non-formulary drugs: Not covered, discounts apply

Notes:
- Balance of charges subject to deductible and coinsurance. No additional Facility Copay if readmitted to the same facility within 72 hours of the initial admission. Facility Copay does not accumulate toward the deductible or out-of-pocket maximum. Facility Copay is still required even if out-of-pocket maximum has been met.
- In-network and out-of-network deductibles are separate and do not accumulate towards each other.
- In-network and out-of-network out-of-pocket maximums are also separate and do not accumulate towards each other.
- Discounted network rates apply for in-network covered services.
- For out-of-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount.
- Co-pays/Coinsurance to in-network and out-of-network providers apply to annual out-of-pocket maximum except where specifically noted in the policy.
Dental Coverage

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

Save money by using our dental network

We have more than 1,300 participating dental PPO dentists in Colorado to choose from. While our dental PPO plan allows you to go to any dentist, you may save the most money when you choose one of these dentists in our PPO provider network. Even better, when you visit a network dentist, you have no deductible or coinsurance to pay for any covered diagnostic or preventive service. For basic and major services, the calendar-year deductible is $50 per person (up to three deductibles per family) and must be satisfied before we will pay any benefits.

Diagnostic and Preventive Care

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

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic oral exams, routine cleanings and X-rays (cleanings limited to two per member per year)</td>
<td>In-network: 100%</td>
</tr>
</tbody>
</table>

Basic Dental Care

Coverage for fillings begins after six months of continuous coverage.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fillings</td>
<td>In-network: 80%</td>
</tr>
</tbody>
</table>

Major Dental Care

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

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extractions, root canals, crowns, dentures</td>
<td>In-network: 50%</td>
</tr>
</tbody>
</table>

*For a copy of our out-of-network fee schedule, please contact your Anthem agent.

Calendar Year Maximum Benefit

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

Losing a loved one is painful enough without having to worry about finances. Give your family extra support with BluePreferred Life™ from Anthem Life Insurance Company. If you’re accepted for coverage on one of our health care plans, you’ll automatically be approved for our term life insurance. Plus, there are no medical exams or additional enrollment forms to worry about. It’s that simple.

**Additional information**

**Save time with automatic premium payment**

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

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

<table>
<thead>
<tr>
<th>Age</th>
<th>$15,000 Benefit</th>
<th>$25,000 Benefit</th>
<th>$50,000 Benefit</th>
<th>$75,000 Benefit</th>
<th>$100,000 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-18</td>
<td>$1.50</td>
<td>$2.50</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>19-29</td>
<td>$2.80</td>
<td>$4.65</td>
<td>$9.30</td>
<td>$11.25</td>
<td>$13.00</td>
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<tr>
<td>30-39</td>
<td>$3.25</td>
<td>$5.40</td>
<td>$10.80</td>
<td>$13.50</td>
<td>$16.00</td>
</tr>
<tr>
<td>40-49</td>
<td>$7.50</td>
<td>$12.50</td>
<td>$25.00</td>
<td>$33.75</td>
<td>$42.00</td>
</tr>
<tr>
<td>50-59</td>
<td>$20.90</td>
<td>$34.80</td>
<td>$69.60</td>
<td>$97.50</td>
<td>$125.00</td>
</tr>
<tr>
<td>60-64</td>
<td>$29.40</td>
<td>$49.00</td>
<td>$98.00</td>
<td>$142.50</td>
<td>$185.00</td>
</tr>
</tbody>
</table>
Make sure you have all the facts

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

“No Obligation” review period

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

Ready to enroll?

Call your Anthem Agent today!

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Services, Inc. Life insurance products underwritten by Anthem Life Insurance Company, Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. ® The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.
To Enroll, You And Your Dependents Must Be:

- Age 64 3/4 or younger and
- A permanent legal resident of Colorado.

Medical Underwriting Requirement

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

- You may be offered coverage at the standard premium rate, or
- You may be offered the plan you selected at a higher rate, or
- You may not qualify for the plan(s) listed in this brochure, or
- You may be offered an alternate plan.

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

Waiting Periods

There is a 12-month waiting period for coverage of any health condition, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received within 12 months preceding the coverage effective date. If you apply for coverage within 90 days of terminating your membership with another ‘creditable’ health care benefits plan, you may use your prior coverage for credit toward the 12-month waiting period. Anthem will credit the time you were enrolled in the previous plan. Consult with your Anthem agent or representative if you have a question about the underwriting process.

Guaranteed Renewability Of All Individual Health Policies

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

- Non-payment of premium
- Fraud/misrepresentation of material fact by the insured
- Anthem elects to discontinue offering all Individual policies
- The state insurance commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders
- The state insurance commissioner finds that the product form is obsolete and is being replaced with comparable coverage

Network Access Plan

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

Colorado Health Plan Description Form

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

Terms Of Coverage

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

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

We may change rates with 30-day advance written notice. We may change coverage or benefits with 90-day advance written notice. Anthem does not change coverage or rates unless the change applies to all covered persons of the same class.
Access To The Medical Information Bureau (MIB)

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

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

The address of MIB’s Information Office is
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734.

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

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

Exclusions and Limitations

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

CoreShare, SmartSense and BluePreferred PPO

Plans Do Not Cover:

- Maternity and pregnancy care
- Acupuncture
- Conditions covered by workers’ compensation or similar law
- Experimental or investigative services
- Services provided by a local, state or federal government
- Services or supplies not specifically listed as covered in the Certificate
- Services received before your plan effective date or after coverage ends, except as stated in your Certificate
- Services you wouldn’t have to pay for without insurance
- Services from relatives
- Any services received by Medicare benefits without payment of additional premium.
- Services or supplies that are not medically necessary
- Routine physical exams, except for preventive care services (e.g., physical exams for insurance, employment, licenses or school are not covered), except as specifically stated in the Certificate
- Any amounts in excess of the maximum amounts listed in the Certificate
- Sex change operations
- Cosmetic surgery
- Services primarily for weight reduction except medically necessary treatment for morbid obesity
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Certificate
- Hearing aids, except as specifically stated in the Certificate
- Infertility services
- Private duty nursing
- Eyeglasses or contact lenses
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Certificate
- Services received for mental and nervous disorders and substance abuse, except as specifically stated in the Certificate
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Certificate.
- Services or supplies related to a pre-existing condition
- Outdoor treatment programs
- Telephone, Internet or facsimile machine consultations
- Educational services except as specifically provided or arranged by Anthem
- Nutritional counseling, food or dietary supplements except as specifically stated in the Certificate
- Personal comfort items
- Custodial care
- Certain genetic testing
- Outpatient speech therapy, except as specifically stated in the Certificate

Lumenos HSA Does Not Cover:

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

Smartsense plans do not cover autism.

BluePreferred PPO does not cover Chiropractic care.

CoreShare and BluePreferred PPO do not cover hair loss.

Lumenos HSA does not cover services primarily for weight reduction, except medically necessary treatment for morbid obesity.

Dental Benefits Which Are Not Covered By Anthem Dental

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

Limitations

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

- Oral Evaluations: Limited to two per calendar year.
- Routine Cleaning or Periodontal Cleaning: Limited to two treatments per calendar year.
- Fluoride: Fluoride treatment limited to two per calendar year for children up to age 19.
- X-rays: Limited to one set of full-mouth X-rays or its equivalent in a five-year period. Periapical X-rays are limited to four films per year.
- Bitewing X-rays: Limited to one set of up to four films twice per calendar year.
- Sealants: Limited to children under 16 years of age for permanent unrestored first and second molars. Treatment is limited to one application per tooth per lifetime.
- Space Maintainers: Limited to once per quadrant per lifetime for children up to age 16. Includes all adjustments within six months of placement.
- Restorations: Limited to once per surface per tooth every 24 months.
- Periodontal Scaling: Limited to once per quadrant every 24 months.
- Periodontal Surgery: Limited to one time per quadrant in a 36-month period.
- Root Canal Therapy: Limited to one treatment per tooth for initial treatment and one retreatment per tooth — for permanent teeth only.
- Stainless Steel Crowns: Limited to baby teeth only. Once per tooth in any five years.
- Crowns: Limited to once per tooth in any five years.
- Removable, Partial and Complete Dentures: Limited to once in five years. Benefits are payable for either complete or immediate dentures, but not both.
- General Anesthesia: Covered only when used in conjunction with covered oral surgical procedures.

Exclusions

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

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

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

Selecting health coverage is an important decision.

To assist you, we are also providing you with the Brochure, Health Plan Description Form and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem agent to request them.

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

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