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- The state insurance commissioner finds that the product form is obsolete and is being replaced with comparable coverage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
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

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.
• 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.