Anthem BlueCross BlueShield

Individual Health Care Plans
for **Colorado**

Our plans fit your plans

SmartSense® Plus Child-Only 2500 Standard Rx

COBR20007SSP Rev. 12/12

Benefits	SmartSense® Plus Child-Only 2500 Standard Rx
Calendar-Year Deductible	**Your Choices**
Individual NETWORK:	$2,500*
Individual NON-NETWORK:	$2,500*
Network Coinsurance Options	30%
Calendar-Year Out-of-Pocket Maximum	**Add Your Chosen Deductible to the Amount Below**
Individual NETWORK:	$5,000
Individual NON-NETWORK:	$9,000
Plan Lifetime Maximum	None
Covered Services	**Your Share of Costs** (after deductible, unless waived)
Doctor's Office Visits	**NETWORK:** · **First 3 Office Visits: $30 Copay,** deductible waived · **Additional Office Visits: 30% Coinsurance** **NON-NETWORK: 50% Coinsurance**
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK: 30% Coinsurance** **NON-NETWORK: 50% Coinsurance**
Inpatient Services (overnight hospital/facility stays)	**NETWORK: 30% Coinsurance** **NON-NETWORK: 50% Coinsurance**
Outpatient Services (without overnight hospital/facility stays)	**NETWORK: 30% Coinsurance** **NON-NETWORK: 50% Coinsurance**
Emergency Room Services	**NETWORK: 30% Coinsurance** **NON-NETWORK: 30% Coinsurance**
Preventive Care Services	Includes preventive services recommended by the United States Preventive Services Task Force, including well child care, immunizations, PSA screenings, pap tests, and more. **NETWORK: 0% Coinsurance, not subject to deductible** **NON-NETWORK:** · **Immunizations** (children under age 13)**:** covered at no cost to member, deductible waived
Maternity	**NETWORK: 30% Coinsurance** **NON-NETWORK: 50% Coinsurance**
Optional Coverage (at additional cost)	Dental, Life
Prescription Drug Coverage	**SmartSense Plus**
Retail Drugs (and Mail-Order Drugs, when available)	**Standard Drug Coverage:** **Tier 1 (Generic drugs): $15 Copay** $7,500 annual Prescription Drug deductible applies before the following: · **Tier 2 (Formulary Brand-name drugs): $40 Copay** · **Tier 3 (Non-Formulary Brand-name drugs): 50% Coinsurance** · **Specialty: 50% Coinsurance** up to a $2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), network only and in addition to $7,500 annual deductible **NON-NETWORK:** Not covered
Optional Drug Coverage (when available)	Not available
Other Covered Benefits include, but are not limited to:	Ambulance, Chiropractic Services, Home Health Care, Severe Mental Health, Physical/Occupational Therapy, Urgent Care
IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Certificate and/or Summary of Benefits. In the event of a conflict between this Benefit Guide and either the Certificate or Summary of Benefits, the Certificate and/or Summary of Benefits will prevail.	*Copays/Coinsurance to network and non-network providers apply to annual out-of-pocket maximum, except where specifically noted in the Certificate. NOTES: - Discounted rates apply for network-covered services. - For non-network services, the member is responsible for the coinsurance plus charges in excess of the allowable amount. - Coinsurance to network and non-network providers applies to the annual out-of-pocket maximum, except where specifically noted in the Certificate.

Give your child every advantage... Good health and a bright smile

Dental Coverage

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

Save money by using our dental network.

We have more than 1,600 participating dental PPO dentist locations in Colorado to choose from. While our dental PPO plan allows your child to go to any dentist, you may save the most money when choosing one of the dentists in our PPO provider network. Even better, when your child visits a network dentist, there is no deductible or member coinsurance for covered diagnostic or preventive services.

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

There are currently no Anthem Blue Dental PPO-contracted dentists available in Archuleta, Baca, Bent, Chaffee, Cheyenne, Crowley, Custer, Dolores, Eagle, Elbert, Gilpin, Grand, Gunnison, Hinsdale, Jackson, Kiowa, Mineral, Moffat, Ouray, Phillips, Pitkin, Rio Blanco, Saguache, San Juan, San Miguel, Sedgwick, Washington and Yuma counties.

Non-network providers will bill members for amounts over what the member's plan pays, up to their usual charge. You will be responsible for any balance of a nonparticipating provider's bill that is more than the maximum allowed amount for nonparticipating providers, in addition to any other copays, coinsurance and deductibles.

The procedures in this brochure are a sample of covered services available to a member. Members who need assistance in determining the maximum payable amount to a non-network dentist may call us at the number on their ID card.

Diagnostic and Preventive Care

Procedure	Plan Pays	
	Network	Non-network
Periodic oral exams, routine cleanings and X-rays *(cleanings limited to two per year)*	100%	Fee Schedule*

Basic Dental Care

Coverage for basic dental care begins after six months of continuous coverage.

Basic Dental

Procedure	Plan Pays	
	Network	Non-network
Fillings	80%	Fee Schedule*

Major Dental Care

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

Major Dental

Procedure	Plan Pays	
	Network	Non-network
Extractions, crowns and root canals	50%	Fee Schedule*

*For more details and a copy of our non-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 term life insurance from Anthem Life Insurance Company.

In most cases, anyone accepted for coverage on one of our health care plans will 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.

Term life monthly rates

Age	$15,000 Benefit	$25,000 Benefit
1-18	$1.50	$2.50

Up to $25,000 in life insurance, with no medical exams and no blood work required. Just check a box on your application and indicate your beneficiary. It's that simple.

Anthem BlueCross BlueShield

Individual health coverage

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 Coverage Details. 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.

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

This Summary of Benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits.

Ready to enroll?

Call your Anthem agent today!

To view a copy of both a Summary of Benefits and Coverage (SBC) and the CO SBC Supplement please visit www.anthem.com/cosbcandsupplement. To view a Summary of Benefits and Coverage please visit healthcare.gov.

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. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Colorado Coverage Details

Things you need to know before you buy...

Anthem Health. Join In.℠

SmartSense® Plus Child-Only 2500 Standard Rx

Before choosing a health care plan for your child, please review the following information, along with the other materials enclosed.

The enrollee must meet the following eligibility requirements:

- Be under 19 years of age.
- Be a permanent legal resident of Colorado.

Open Enrollment:

Open Enrollment periods occur every January 1-31 and July 1-31, followed by a 30-day waiting period with a policy effective date of March 1st or August 31st. Applications must be received during the Open Enrollment period.

Anthem must receive the application by 3 p.m. MT (5 pm ET) the last day of the Open Enrollment period.

Qualifying Events:

Applications will be processed for Child-Only plans if Anthem receives the application within 30 days of a qualifying event listed below. Coverage can start on any day of the month after the date we receive the application for a qualifying event. For example, if an application is received on October 30; the effective date can be October 31.

Qualifying events include:

- Lost employer-sponsored health insurance;
- Lost eligibility under the Colorado Medical Assistance Act or the Children's Basic Health Plan;
- Involuntarily loss of other existing coverage for any reason other than fraud, misrepresentation or failure to pay premium;
- Marriage or dissolution of marriage;
- Entry of a valid court or administrative order mandating the child be covered; or
- Birth or adoption.

The birth month of a child is not a qualifying event.

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 Blue Cross and Blue Shield (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 be eligible if other creditable coverage is available.

Guaranteed Renewability of All Individual Health Policies

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

- Nonpayment of premium
- Any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact by the insured
- If Anthem elects to discontinue offering all Individual policies
- If the state insurance commissioner finds that the continuation of the coverage would not be in the best interests of the policyholders
- If 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 Benefit Plan Description Form

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate the 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 must also 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 Benefit 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 child's 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 that 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 **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.

Utilization and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific time frames to ensure requests are handled in a timely manner. Our Case Management services help you to better understand and manage your health conditions.

Prospective Review/Pre-Admission Review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary; and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for prospective review may include, but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care, and assigns expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians and member-assigned health care professionals (or member-authorized representative), and takes place by telephone, electronically and/or on-site.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g., without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed health care professionals who work with you and your doctor to help you understand your benefits and support your health care needs.

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 Benefit Plan Description Form and Certificate.

The SmartSense® Plus Child-Only 2500 Standard Rx Plan Does Not Cover:

- Acupuncture
- Autism
- 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 exams and immunizations related to sports, insurance or condition of employment; for licensing, school, church or camp; or for routine care received in the emergency room

- 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
- Hair loss, even if there is a physician prescription and a medical reason for the hair loss
- 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, for applicants age 19 and older
- 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

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

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Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Coverage Details, Enrollment Application and Health Statement. If you did not receive one or more of these materials, please contact your Anthem Broker to request them.

Anthem®

Health. **Join In.**℠

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