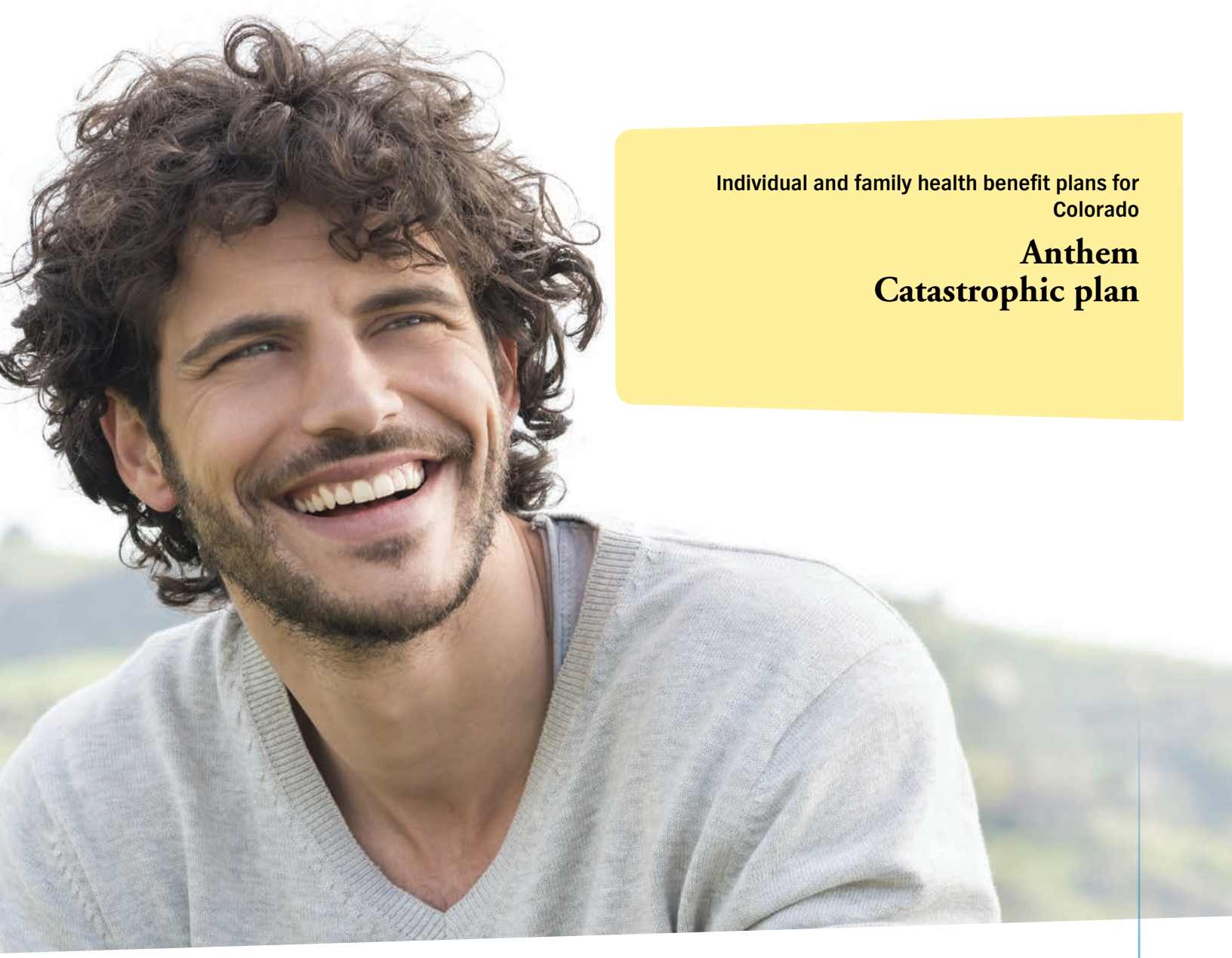
Anthem BlueCross BlueShield



Individual and family health benefit plans for Colorado

Anthem Catastrophic plan

Looking for a new health plan? We can help.

At Anthem Blue Cross and Blue Shield and HMO Colorado (Anthem), our Catastrophic plan has one major goal in mind: To help you stay healthy and find the quality coverage you need when you need it. That's why you're covered from preventive care to emergencies, and more!

03636COMENABS 8/14

What's covered?

- In-network preventive care services, including screenings, and help managing a chronic (ongoing) disease
- Outpatient services
- Emergency services, like going to the emergency room (ER) or urgent care center (when necessary)
- Inpatient services (care received when you stay overnight in a hospital)
- Laboratory services (blood work, screenings)
- Prescription drugs
- Rehabilitative and habilitative services (habilitative services help a person learn, keep or improve skills they may not be developing normally)
- Mental health and substance abuse services
- Maternity (pregnancy) and newborn care
- Pediatric services (health care for children)
- Durable medical equipment (Durable medical equipment or DME includes medical equipment and supplies for things like hospital beds, crutches, wheelchairs and oxygen tanks)

Take a closer look at prescription drug coverage

Prescription drug benefits help cover the cost of medications your doctor prescribes. We're here to help you better understand how our prescription drug plans work and the choices you have when it comes to selecting and paying for these medications. Always talk to your doctor first about which medication is right for you.

Select drug list (drug formulary)

All of our prescription drug plans have a formulary, called the Select Drug List. The Select Drug List is not a complete list, but is simply a list of the most commonly used FDA-approved drugs that your plan covers.

Prescription drug tiers

Every drug on the Select Drug List is assigned to a certain tier (or level) based on cost, availability of over-the-counter alternatives, clinical information and certain drugs used to treat the same or similar condition. The drug list tells you what tier your drug is in and related details on coverage. What you pay for your prescription depends, in part, on which tier your drug is in. For example, Tier 1 usually includes preferred generic drugs with the lowest cost to you. As the tier number increases, the drugs in that tier generally cost you more. If your drug is in a higher tier, you may want to speak with your doctor to find out if one of the drugs covered in a lower tier will work for you.

For more information, go to anthem.com:

- To find out if your medication is covered, take a look at our drug list at www.anthem.com/COSelectdrugtier4.
- To learn more about pharmacy processes (such as prior authorization, step therapy, quantity limits, dose optimization), check out the FAQs at Customer Support > FAQs > FAQ Categories > Pharmacy.
- To see if your pharmacy is in our network, visit our Find a Doctor tool.

The doctors you can see

When you choose this health plan, you pick a primary care physician (PCP). Having a primary physician you see anytime you need a checkup or a health issue is a good idea. You have a choice of in-network PCPs. When you need to see other doctors, a referral from your PCP is not required.

Using in-network doctors can help you save

When you need care, you will get the best value by visiting **in-network** doctors, hospitals or other health care providers. **In-network** (or participating) refers to doctors, hospitals and other health care providers that have agreed to accept lower negotiated rates (discounted prices) for their covered services. These agreed upon rates can help lower the cost of covered health care services, including your share of the costs. This is true when you're paying the whole cost for covered services (such as while you are meeting your deductible). And it's also true when we are sharing the cost (while you are meeting your out-of-pocket limit).

Out-of-network (or nonparticipating) refers to doctors, hospitals and other health care providers that are not contracted with Anthem to provide services at a negotiated rate. **This plan does not offer out-of-network benefits (with the exception of emergency, urgent care and ambulance services or when we authorize care).** This means you will pay the entire cost for any service you get from **out-of-network** providers.

With this plan, you also have access to the Away From Home Care or Guest Membership program that allows you or any of your covered dependents temporarily living away from home to become guests on an affiliated Blue Cross and Blue Shield HMO plan in the area where they're staying. Guest membership is not available in all areas. Once you become a member, call Member Services to learn more.

To find out if your current health care provider is in our **Pathway** network, visit our Find a Doctor tool on anthem.com.

Below is a listing of commonly used benefits and how they're covered under this plan. **Cost share and benefit information in this snapshot is for in-network covered services.** If you need more information about a benefit that is not listed here, please check with your broker or Anthem authorized representative. You can also view and compare plans on anthem.com. To view a copy of both a Summary of Benefits and Coverage (SBC) and the CO SBC Supplement, please visit www.sbc.anthem.com > Select Member.

Anthem Catastrophic Pathway HMO 6600/0%

Network Name	*Pathway*
Plan includes out-of-network coverage?[1]	No
Individual Deductible (Family[2] = 2 x Individual amount)	$6,600
Individual Out-of-pocket Limit (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x Individual amount)	$6,600
Coinsurance	0% coinsurance
Office Visit: Primary Care Physician (PCP) (includes post natal visits) NOTE: Other office services subject to deductible and plan coinsurance.	$40 copay per visit for first 3 office visits, then deductible and 0% coinsurance
Office Visit: Specialist	Deductible, then 0% coinsurance
Outpatient Diagnostic Tests (Examples: X-ray, EKG)	Deductible, then 0% coinsurance
Outpatient Advanced Diagnostic Tests (Examples: MRI, CT scan)	Deductible, then 0% coinsurance
Preventive Care[3]	No additional cost to you
Urgent Care	Deductible, then 0% coinsurance
Emergency Room Care	Deductible, then 0% coinsurance
Hospital: Inpatient Admission (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then 0% coinsurance
Hospital: Outpatient Surgery Hospital Facility	Deductible, then 0% coinsurance
Retail Pharmacy Deductible	Combined with medical deductible
Retail Pharmacy Tier 1[4,5]	Deductible, then 0% coinsurance
Retail Pharmacy Tier 2[4,5]	Deductible, then 0% coinsurance
Retail Pharmacy Tier 3[4,5]	Deductible, then 0% coinsurance
Retail Pharmacy Tier 4[4,5]	Deductible, then 0% coinsurance
Dental[6,7]	Pediatric dental covered / Adult dental not covered
Vision	Pediatric vision covered / Adult vision not covered
Mental Health and Substance Abuse: Outpatient Facility & Services	Deductible, then 0% coinsurance
Physical, Occupational and Speech Therapy[8]	Deductible, then 0% coinsurance

1 **This plan only includes out-of-network benefits for emergency care, urgent care and ambulance services. In addition, we offer Guest Membership (also called Away from Home Care) with this plan.**

2 This plan has an **embedded family deductible** where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

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

4 **Prescription drugs:** You'll use the home delivery pharmacy, managed by Express Scripts, Inc., instead of a retail pharmacy, for drugs you take on a regular basis (e.g. maintenance medicines). If you are taking a maintenance medication, you may get the first 30-day supply plus one additional 30-day refill of the same maintenance medication at your local retail pharmacy. You must then use the home delivery pharmacy.

5 **Prescription drugs:** Covered medications are assigned to certain tiers (or levels) based on cost, availability and similar alternatives. Our plans have multiple tiers. Tier 1 medications may have a lower cost share for the member.

6 **Pediatric dental** is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

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

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

In accordance with the Affordable Care Act, benefits, formularies, pharmacy and provider networks, premiums and copayments/coinsurance for these plans may change on January 1 of each year.

Eligibility for a catastrophic plan

You are eligible for this plan if you:

- are under age 30 before the plan's effective date

or

- have received certification from Connect for Health Colorado that you are exempt from the individual mandate because you qualify for a hardship exemption or do not have an affordable coverage option

When you can purchase a plan

Generally, plans can be purchased once a year through an open enrollment period. For 2015 enrollment, the open enrollment period runs from November 15, 2014 through February 15, 2015. The annual open enrollment period may vary from year to year, so you should check with your broker or Anthem authorized representative for more information.

When certain events occur in life, you can enroll in a plan

There are a lot of life events — from having a baby to moving to a new state — that may allow you to change your health plan during a **special enrollment period**. These are called "qualifying events." If you've had a change in your coverage, family or income that qualifies, you can shop for a new health plan without waiting for the next open enrollment period.

Let us know if you're:

- Losing coverage at work
- Getting married or divorced
- Having a baby or adopting a child
- Turning 26 and no longer covered under your parents' plan
- Experiencing other changes in your coverage, family or income
- Moving soon or just moved

Don't wait too long. Most people have only 60 calendar days after a qualifying event to enroll in a new plan. You'll need to show proof of the qualifying event.

Check with your broker or Anthem authorized representative for effective date options and guidelines around enrollment during other times of the year.

Purchasing a catastrophic plan for a family

As long as each family member meets the eligibility requirements for enrollment in the plan, a family can purchase this plan.

Premium tax credits

Individuals purchasing a catastrophic plan are not eligible for help in paying their premiums.

Follow these easy steps to enroll

What you'll need

Before you begin the enrollment process, be sure to have these handy:

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

How to enroll in this Anthem plan

- Call your broker or Anthem authorized representative to enroll or learn more about the health care plans offered by Anthem
- Visit our website at anthem.com and apply online

Anthem BlueCross BlueShield

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

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

Anthem does not discriminate based on race, color, ethnicity, national origin, religion, age, gender, gender identity, mental or physical disabilities, sexual orientation, genetic information, including pregnancy and expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health condition or health status in the administration of the plan, including enrollment, marketing practices, benefit designs, and benefit determinations.

Coverage Details for Colorado

Anthem BlueCross BlueShield

Things you should know before you buy these plans...

Anthem Bronze Pathway HMO plans 5000/40%, 5750/30%, 6250/20%, 25% for HSA and 0% for HSA; Anthem Bronze Mountain Enhanced HMO 5000/40%; Anthem Bronze PPO plans 5000/20%, 6200/30% and 20% for HSA; Anthem Silver Pathway HMO plans 1250/35%, 1750/20%, 2000/25%, 2250/10% and 2500/10%; Anthem Silver Mountain Enhanced HMO 2000/25%; Anthem Gold Pathway HMO 1100/10%; Anthem Gold Mountain Enhanced HMO 1100/10%; and Anthem Catastrophic Pathway HMO 6600/0%

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

Eligibility

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

Open Enrollment

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

Special Enrollment and Changes Affecting Eligibility

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

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

Effective Date of Coverage

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

Guaranteed Renewable

Coverage under the Booklet is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law. As a member, you may renew the Booklet by payment of the renewal premium by the end of the grace period of the premium due date, provided the following requirements are satisfied:

1. Eligibility criteria, as set forth in the Booklet, continues to be met;
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of the Booklet; and
3. Membership has not been terminated by Anthem or HMO Colorado under the terms of your Booklet.

In-network Providers

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

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

Services you obtain from any provider other than a PCP, SCP or another in-network provider are considered a non-network service, except for emergency care or urgent care.

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; or
- The services are approved in advance by Anthem.

Covered services which are not obtained from a PCP, SCP or another in-network provider or not an authorized service will be considered a out-of-network service. The only exceptions are emergency care and urgent care. In addition, certain services are not covered unless obtained from an in-network provider. See your Summary of Benefits.

For PPO plans, services will be covered services if rendered by out-of-network providers, but your share of the costs may be greater.

For services rendered by an out-of-network provider, you may be 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

How to Find a Provider in the Network

There are three ways you can find out if a provider or facility is in the network for one of these plans. You can also find out where they are located and details about their license or training.

- See your Plan's directory of in-network providers at anthem.com, which lists the doctors, providers, and facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of doctors and providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your doctor or provider.

When using the Find a Doctor tool, be sure to include the plan network (Pathway, Mountain Enhanced or PPO Statewide) as search criteria for the plan you are considering.

If you need help choosing a doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

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

If you or a family member needs 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 Management

Utilization management (UM) is a program that is part of your health plan. It lets us make sure you're getting the right care at the right time. Our UM 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 needed. The UM review team checks to make sure the treatment meets certain rules set by your health plan. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The UM review team will let you and your doctor know as soon as possible.

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

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

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

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

The concurrent review (done during medical care and recovery)

We do a concurrent review when you are in the hospital or are released and need more care related to the hospital stay. This could mean services or treatment in a doctor's office, regular office visits, physical therapy or mental health therapy, home health care, durable medical equipment, a stay in a nursing home, mental health care visits and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically needed.

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

We do a retrospective review when you have already had surgery or another type of medical care. When the UM 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 needed.

Case Management

Case managers are licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

Preauthorization

Preauthorization 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 preauthorization guidelines regularly. Preauthorization is also called "precertification," "prior authorization," or "pre-approval."

Here's how getting preauthorization can help you out:

Saving time. Preauthorizing services can save a step since you will know if you are eligible and what your benefits are before you get the service. The doctors in our network ask for preauthorization for our members.

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

What can you do? Choose an in-network doctor. Talk to your doctor about your conditions and treatment options. Ask your doctor which covered services need preauthorization or call us to ask. The doctor's office will ask for preauthorization for you. Plus, costs are usually lower with an in-network doctor. If you choose an out-of-network provider, be sure to call us to see if you need preauthorization. Out-of-network providers may not do that for you. If you ever have a question about whether you need preauthorization, just call the preauthorization or precertification phone number on your ID card.

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.

Exclusions

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

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

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:

- Applied behavior analysis for autism
  - From birth through age 8: 550 sessions, 25 minutes in length per year
  - Age 9-19: 185 sessions 25 minutes in length per year
  - Depending on the law, you may be entitled to exceed these maximums
- Hearing aids - 1 pair every 5 years for members under age 18
- Home health care - 28 hours per week
- Rehabilitative care (outpatient only) - An equal number of therapy visits are available for habilitative care (outpatient only)
  - Physical therapy - 20 visits per member per year
  - Occupational therapy - 20 visits per member per year
  - Speech therapy - 20 visits per member per year
- Skilled nursing facility - 100 days per year

To access a Summary of Benefits and Coverage (SBC) and the CO SBC Supplement, please visit www.sbc.anthem.com > Select Member.

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

- Review the Booklet.
- Call your Anthem authorized representative.
- Go to anthem.com.

In accordance with the Affordable Care Act, benefits, formularies, pharmacy and provider networks, premiums and copayments/coinsurance for these plans may change on January 1 of each year.

The health plans described within this document are not eligible for a premium tax credit/subsidy or cost-sharing assistance. Health care reform, or the Affordable Care Act (ACA), lets people with low or modest incomes use a premium tax credit to help pay for their health insurance. You can only get financial help if you are eligible and buy your individual health coverage through Connect for Health Colorado.

Selecting health coverage is an important decision.

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

Division of Insurance

COLORADO UNIFORM INDIVIDUAL APPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's initial application for coverage. Please contact your carrier with questions regarding this form.

Federal financial assistance may be available for coverage purchased through Connect for Health Colorado. If purchasing coverage through Connect for Health Colorado, you will need to provide additional information for determination of eligibility for federal financial assistance. Further information may be found at www.connectforhealthco.com.

COVERAGE INFORMATION

Application Type:	☐ New Coverage ☐ Change/Modification to Existing Coverage ☐ Open Enrollment ☐ Special Enrollment*
Requested Effective Date:	_____/_____/_____ (MM/DD/YYYY)

* Proof of eligibility for special enrollment will be required – information on eligibility for special enrollment periods is available at: www.dora.colorado.gov/DOI/HealthApp

PRIMARY APPLICANT/INSURED INFORMATION

Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.

First Name:		Middle Initial:		Last Name:	
Social Security #:		Date of Birth:	/ /	Current Age:	Sex: ☐ M F ☐
Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	

Are you (check one): ☐ Single ☐ Married ☐ Common Law* ☐ Civil Union* ☐ Legally Separated ☐ Divorced ☐ Under 21

Are you or is anyone in your family American Indian or Alaskan Native? ☐ Yes ☐ No

* A common law, civil union, or designated beneficiary certification may be required by the carrier

Employer Name and Address:		Work Phone:	

ADDITIONAL APPLICANTS

Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26(older if medically disabled) are applying for coverage. If a dependent child is applying an as individual rather than as part of a family list the child as the primary applicant. If there is not enough space provided, please attach additional family information. **Please sign and date the additional sheet.**

*Social Security Numbers (or document numbers for any legal immigrants) are needed for anyone applying for health insurance, missing numbers will be requested after enrollment

Name (First, MI, Last)	Sex	Social Security #	Relationship	Disabled	Birth Date (MM/DD/YY)	Employer Name and Position
	☐ M ☐ F		SPOUSE/PARTNER			
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		

Do(es) the child(ren) named within the application live with you at the same physical address shown above? ☐ Yes ☐ No (if no, complete below)

Child(ren)'s Name:			Mailing Address (If different):				
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Primary Applicant Name:

Name of the Legal Guardian or Parent responsible for carrying health insurance for the child:							
If the primary applicant is under the age of 21 if different from above, provide the name and mailing address of the legal guardian or custodial parent:							
Legal Guardian or Custodial Parent's Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

TOBACCO USE

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."

Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		

MEDICARE/MEDICAID INFORMATION

Is any applicant enrolled in Medicare? ☐ Yes ☐ No

Name of person covered by Medicare: _____. For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program? ☐ Yes ☐ No

Name of person covered by Medicaid or other governmental health program: _____. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? ☐ Yes ☐ No

(Dental Coverage in next Section)

Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type

If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted? ☐ Yes ☐ No

Type of Coverage Key: **G** = Group Comprehensive Major Medical; **I** = Individual Comprehensive Major Medical; **MS** = Medicare Supplement; **H** = Hospital Coverage Only; **V** = Vision Coverage Only **O**=Other, please explain:_____

Primary Applicant Name:

CERTIFICATION OF DENTAL INSURANCE COVERAGE (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required provide proof that you have obtained coverage before this policy will be approved

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved. (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)

I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I would like to receive all policy notices, premium notices, and other notices relating to this policy through the supplied email address above. ☐Yes ☐No

I understand I can change this designation at a later date by contacting my carrier directly, and understand it is my responsibility to notify my carrier of any changes to my email address.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	Date Signed:

Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:

Primary Applicant Name:

AGENT/PRODUCER INFORMATION	
This section is to be completed by Agent or Producer.	
Agent / Agency of Record: (for commissions and correspondence)	Writing Agent / Producer:
Name (print):	Name (print):
Agent ID # (NPR):	Agent ID #(NPR):
Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐ Yes ☐ No As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature.	
Writing Agent Signature	**Date**

DISCLOSURES

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://www.dora.colorado.gov/insurance. For questions regarding coverage or enrollment please see your carrier.

This section may be used to provide additional information that was required in the sections above and did not fit in the space provided.

Signature of Primary Applicant: _____ **Date Signed:** _____

Colorado
Individual Enrollment Application Supplement Form

NOTE: THIS APPLICATION IS ONLY TO BE USED IN CONJUNCTION WITH THE UNIFORM INDIVIDUAL APPLICATION.

PLEASE NOTE: If you are a new customer, you have to send in the premium payment with each application. If you already have an Individual policy with us, you have to pay premium before the requested start date of your plan. Please fill out the Payment Method for Individual Applications Form and send it with your application. If you do not pay premium as above, we will not approve your application. If you need help with this application, please call your insurance agent. If you do not have an insurance agent, call 1 (877) 212-1793. If you have questions about a previously submitted application, please call 1 (855) 383-7249.

Please complete in blue or black ink only.

Section A – Coverage Information

First Name	MI	Last Name	Date of Birth (mm/dd/yyyy) / /

Effective Date:

As explained below, your effective date of coverage may vary depending on the type and time of enrollment. If the effective date of coverage, as determined by us, is different from the effective date you requested in the application, our determination of the effective date controls.

Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. The earliest Effective Date for the annual Open Enrollment period is the first day of January. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable premium payment.

Outside the Open Enrollment period referenced above, the applicant may still enroll if he/she has a qualifying event as defined below. Following a qualifying event, an applicant has 60 days to submit an application. In the case of a future Loss of Minimum Essential Coverage, applications may be submitted up to 30 days in advance of the qualifying event date.

Qualifying Events

Please check the type of enrollment or qualifying event:

- ☐ Open Enrollment;
- ☐ Involuntary Loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;
- ☐ Loss of Minimum Essential Coverage due to dissolution of marriage/domestic partnership/civil union;
- ☐ Marriage/Domestic Partnership/Civil Union;
- ☐ Birth or adoption or placement for adoption or appointment of guardianship;
- ☐ Moved to a new exchange service area or immigration status changed to lawfully present;
- ☐ Other Qualifying Event: _____ (Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events).

Please provide the date of the qualifying event (which includes the date of Loss of Minimum Essential Coverage): _____

If you are applying due to a qualifying event and your application is approved, your effective date is as follows:

- In the case of birth, adoption or placement for adoption or appointment of guardianship, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship; or
- In the case of marriage, or Loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application.
- In the case of all other qualifying events, where individual coverage is purchased between the first and fifteenth day of the month, coverage shall become effective the first day of the following month. Where individual coverage is purchased between the sixteenth and last day of the month, coverage shall become effective the first day of the second following month.

Are all applicants listed on the Individual Uniform Application legal residents of the United States and residents of the state in which you are applying for coverage? ☐ Yes ☐ No

If **NO**, who? _____

Are all applicants listed on the Individual Uniform Application United States citizens, nationals or lawfully present non-citizens? ☐ Yes ☐ No

If **NO**, who? _____

☐ Applicant **DOES** speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a "Statement of Accountability".

Section B – Medical Coverage

Plan Name and Deductible/Coinsurance Options

Select ONE Plan…then select ONE Individual Deductible/Coinsurance option.
Total Family Deductible is two (2) times the amount shown.

Anthem Bronze Pathway HMO
☐ $5,000/40% - (1G0P) ☐ $5,750/30% - (1G0R) ☐ $6,250/20%- (1G0X)

Anthem Bronze PPO
☐ $5,000/20% - (1G10) ☐ $6,200/30% - (1G0Y)

Anthem Silver Pathway HMO
☐ $1,250/35% - (1G1G) ☐ $1,750/20% - (1G1R) ☐ $2,000/25% - (1G1B)
☐ $2,250/10% - (1G1X) ☐ $2,500/10% - (1G1M) ☐ $2,500/10% - (1G1Y)

Anthem Gold Pathway HMO
☐ $1,100/10% - (1G24)

☐ **Anthem Catastrophic Pathway HMO (only available for Applicants under age 30 or otherwise qualified)**
☐ $6,600/0% - (1G27)

Applicants must reside in one of these counties to enroll: La Plata, Montezuma, Summit or Eagle.

Anthem Bronze Mountain Enhanced HMO
☐ $5,000/40% - (1JR7)

Anthem Silver Mountain Enhanced HMO
☐ $2,000/25% - (1JR2)

Anthem Gold Mountain Enhanced HMO
☐ $1,100/10% - (1G2F)

HSA Plans

☐ **Anthem Bronze Pathway HMO 25% for HSA – (1G0V)**
☐ **Anthem Bronze Pathway HMO 0% for HSA – (1G0T)**
☐ **Anthem Bronze PPO 20% for HSA – (1G0Z)**

☐ **YES**, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Anthem's banking partner. (Please fill in your social security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Anthem's banking partner.

Please choose a Primary Care Physician for each family member from the Provider Directory, which can be found at www.anthem.com, or by calling 1 (888) 231-5046. If you do not choose a PCP, then one will be selected for you.

Applicant	**Primary Care Physician (PCP)**	**PCP ID**	**Current Patient**	**PMG/IPA ID***
Primary Applicant			☐ Yes ☐ No	
Spouse/ Domestic Partner			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	

**PMG = Participating Medical Group, IPA = Independent Practice Association*

☐ Please check box if any additional sheets of paper have been completed for this section. If so, please attach and return the additional sheets with this application.

Section C – Other Health Coverage

Important information about replacement and duplicate coverage:
Normally you do not require more than one of the same type of policy, but if you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy. If you are eligible for Medicare due to age or disability, counseling services are available in Colorado to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

If **YES**, please indicate your eligibility:

- ☐ Specified Low Income Medicare Beneficiary (SLMB)
- ☐ Qualified Medicare Beneficiary (QMB)
- ☐ Other Medicaid medical benefits (please explain)_____

Do you, or anyone applying for coverage, currently have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy? ☐ Yes ☐ No

If YES, please provide the following:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage

Will you be cancelling this coverage if approved for Anthem coverage? ☐ Yes ☐ No

If **YES**, what is the cancellation date? _____

If **YES**, do you intend to replace your current accident and sickness insurance with this policy (contract)? ☐ Yes ☐ No

If **YES**, please read the following: According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield or HMO Colorado. Your new policy will provide 10 days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

_____ **Additional benefits**

_____ **No change in benefits, but lower premiums**

_____ **Fewer benefits and lower premiums**

_____ **Other** (please specify)

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer or Other Representative* X	Date
Typed Name and address of Issuer or Producer X	Date
Applicants Signature X	Date

*Signature not required for direct response sales.

Premium Reimbursement:

1. Will an employer of fifty (50) or fewer eligible employees be paying for or reimbursing you through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for? ☐ Yes ☐ No

If you answered "yes", please continue. If you answered "no", you may stop.

2. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve (12) months prior to the date of this application? ☐ Yes ☐ No

If the answer to both questions 1 and 2 immediately above is "yes", you may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

If the answer to question 1 is "yes" and the answer to question 2 is "no" , you must submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months.

The affidavit form to be executed by the employer is attached at the end of this form. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier.

Section D – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

I understand that under the Anthem plan I have asked for, I will get less benefits if I use an out-of-network provider than if I use an in-network provider.

- I understand that although Anthem takes payment with my application, the sending or receiving of my payment does not mean that coverage has been approved. I understand that, where the law allows, Anthem may decline this application, and that no right is created by this application. If my application is denied, my bank account or credit card will not be charged.
- I agree to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
- I understand Anthem may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem automatic debit process and will only occur each time I send a check to Anthem. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
- By signing below, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
- I understand that my domestic partner if any, is eligible only in certain cases. I agree that my partner: has been my sole domestic partner for 12 months or more; is mentally competent; is at least 18 years old; is not related to me in any way that would prohibit us from being married under state law; is not married to or separated from anyone else; and is financially interdependent with me.
- ☐ By checking this box, I authorize and expressly consent that Anthem and its affiliated companies may send and deliver to me any communication that is not required to be provided to me by United States mail, including but not limited to legally required Plan Notices, policies, agreements, evidence of coverage booklets and underwriting, enrollment and billing and explanation of benefits statements, electronically, either by e-mail or via the Internet. Examples of documents that will not be sent by electronic means and will continue to be sent by U.S. Mail include notices of cancellation, notices of grace period, notices that will terminate your coverage, and notices regarding a denial of coverage. I understand that I can revoke this authorization or request paper copies at any time by contacting Anthem customer service or online at www.anthem.com.
- As part of the W-9 Certification required by the Internal Revenue Service, I certify that the SSN number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

By signing below, I agree that I have read the TERMS and I accept them as a conditions of coverage. I represent that the information on this application are true and accurate to the best of my knowledge and belief. I understand that Anthem is relying on this representation in agreeing to accept this application. I agree that any act, practice, or omission that amounts to fraud or intentional misrepresentation of material fact may result in benefits being denied or my coverage being cancelled.

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative.

Rescission of Membership

I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered in this application, Anthem may revoke my coverage. This means Anthem may cancel membership as if it never existed. Also, after approval for membership, if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered by Anthem that was not provided to Anthem prior to the effective date of the policy, the plan may revoke coverage.

I understand that if my coverage is revoked, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for enrollment.

I also understand that I may be required to pay for any claims that were paid while a member and that Anthem will refund all amounts paid by me except amounts owed to Anthem.

I have personally read and completed this application. If I am accepted, this application will become part of the contract between Anthem and me. I agree to abide by the terms of that contract.

REQUIREMENT FOR BINDING ARBITRATION:

I UNDERSTAND AND AGREE THAT ANY AND ALL DISPUTES BETWEEN ANTHEM AND ME MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE AFFORDABLE CARE ACT. ANTHEM AND I AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN OUR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT ANTHEM AND I ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANYOTHER ISSUES RELATED TO THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

BEFORE COMMENCING ARBITRATION, THE PARTY SEEKING ARBITRATION MUST HAVE EXHAUSTED ALL LEVELS OF APPEAL AND REVIEW SET FORTH IN THE CERTIFICATE. ANY SUCH ARBITRATION WILL BE GOVERNED BY THE PROCEDURES AND RULES ESTABLISHED BY THE AMERICAN ARBITRATION ASSOCIATION. THE LAW OF THE STATE IN WHICH THE POLICY WAS ISSUED AND DELIVERED TO THE POLICYHOLDER SHALL GOVERN THE DISPUTE. THE DECISION IN ARBITRATION IS BINDING UPON BOTH ANTHEM AND ME. THE AWARD GIVEN IN ARBITRATION MAY BE ENFORCED OR REVIEWED IN ANY COURT THAT HAS PROPER JURISDICTION. IN THE EVENT ANY PERSON SUBJECT TO THIS ARBITRATION CLAUSE INITIATES LEGAL ACTION OF ANY KIND, THE OTHER PARTY MAY APPLY FOR A COURT OF COMPETENT JURISDICTION TO ENJOIN, STAY OR DISMISS ANY SUCH ACTION AND DIRECT THE PARTIES TO ARBITRATE IN ACCORDANCE WITH THIS PROVISION. THE QUESTION OF WHAT DISPUTES ARE SUBJECT TO THIS ARBITRATION CLAUSE SHALL BE DETERMINED BY THE ARBITRATOR.

IF AN APPLICANT DOES NOT READ ENGLISH, THE TRANSLATOR MUST SIGN AND SUBMIT A STATEMENT OF ACCOUNTABILITY FOR TRANSLATING THIS ENTIRE APPLICATION (SEE SECTION F).

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING, BY THE EXTENT PERMITTED BY STATE OR FEDERAL LAW, TO HAVE ANY AND ALL DISPUTES AGAINST ANTHEM BLUE CROSS AND BLUE SHIELD DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO JURY OR COURT TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS AND ANY OTHER DISPUTES. SIGNATURES REQUIRED.

SIGN HERE

Signature of Applicant* or Legal Representative X	Date
Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section E – Agent/Broker Information

Agent/Broker Signature X	Date
Agent/Broker Name (please print)	Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No.

Agent/Broker ID/TIN	Agency ID/Parent TIN	City	State	ZIP

Agent/Broker Phone No.	Agent/Broker Fax No.	Agent/Broker E-mail

GA (if applicable)	GA code (if applicable)

Section F – Statement of Accountability

To be completed when the applicant cannot complete application.

NOTE: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I, _____ , personally read and completed this Individual Enrollment Application for the applicant named below because:

☐ Agent assisted application ☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain):_____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the: ☐ Applicant Or by:_____

I also translated and fully explained the "Significant Terms, Conditions, and Authorizations (TERMS)" and "Payment Method".

Translator Signature ***(Required)***	Today's Date ***(Required)***
X	

I confirm that the application was interpreted on my behalf.

Applicant Signature ***(Required)***	Today's Date ***(Required)***
X	

Employer Affidavit (obtain only if required by Section C of this application)

Employer's Name: _____

Employer's Address: _____

_____

The undersigned officer or principal of the employer identified above certifies that:

1. The employer is a small employer as defined in § 10-16-102(61), C.R.S., with fifty (50) or fewer eligible employees;

2. The employer has not had in place a small group health benefit plan for the twelve (12) months prior to the execution of this affidavit.

3. A false certification may cause the rescission of the employee's individual insurance policy and subject the employer to penalties for perjury and liability to the employee.

Signature X	Date
Typed Name X	Date
Position	Date

Please mail this application to the following address:

Anthem Blue Cross and Blue Shield

P.O. Box 9041

Oxnard, CA 93031-9041

Or

Fax to: 1 (800) 327-9255

Payment Methods for Individual Applications – Colorado

Anthem BlueCross BlueShield

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Automatic Premium Payment (complete Section A)

☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account
☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)

Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield ("Anthem") to pay and charge to my account checks drawn on that account by and made payable to the order of Anthem Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing Anthem a 30-day written notice. I agree that Anthem shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Anthem's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield ("Anthem") to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **Anthem accepts Visa and MasterCard.**

Card Number:

Expiration Date:

Billing address for this Credit / Debit Card:

City:

Zip Code:

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize Anthem either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Anthem uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.

How to enroll

Sign up today for our dental and vision plans!

For Dental Prime plans:
Fill out a form online or by hand.

- Go to AnthemDentalAdmin.com.
- Or fill out and sign the appropriate form. Then give the form to your agent or mail it to us at:

  Dental Enrollment Department
  P.O. Box 1193
  Minneapolis, MN 55440-1193

For Anthem Dental Pediatric, Anthem Dental Family, Anthem Dental Family Enhanced plans:

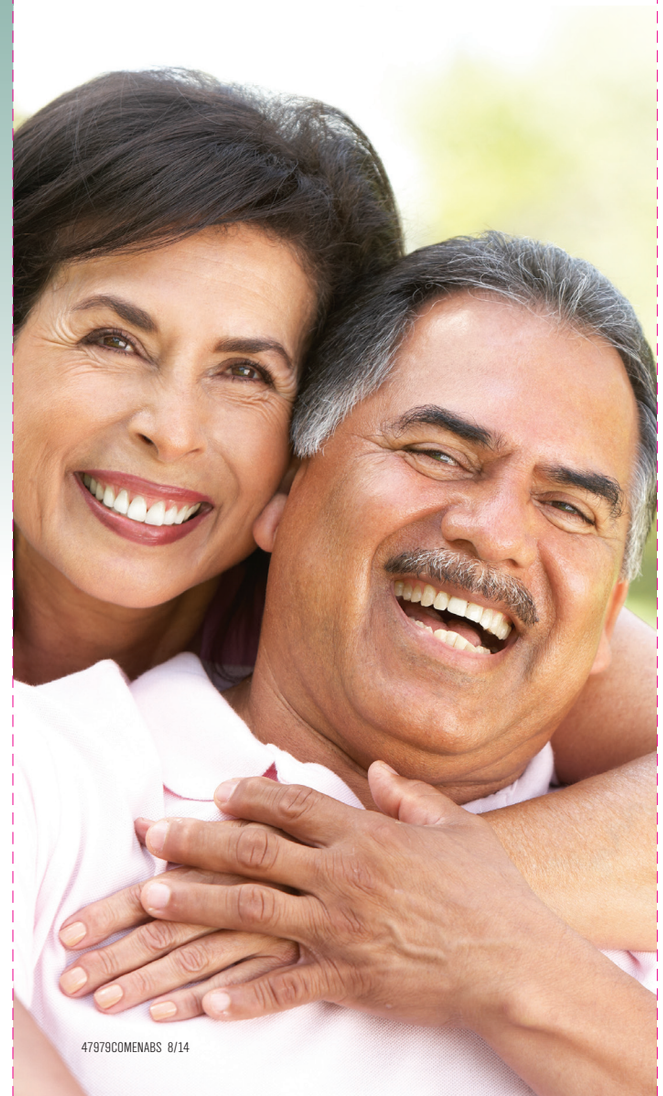
Fill out and sign the form. Give your completed form to your agent or mail it to us at:

Dental Enrollment Department
P.O. Box 9041
Oxnard, CA 93031-9041

Anthem BlueCross BlueShield

Anthem BlueCross BlueShield

Dental and vision coverage for your total health



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Anthem dental plans

We offer a variety of individual and family dental plan options to fit your needs and budget. These plans include:

- Dental Prime for Individuals and Families with optional Vision benefits.
- Anthem Dental Pediatric, Anthem Dental Family and Anthem Dental Family Enhanced plans

Health care reform

Essential health benefits include dental and vision

Pediatric dental is one of the 10 essential health benefits that are included in nearly all individual medical plans as of January, 2014.

Consumers have the following purchase options if they need or want pediatric dental essential health benefits:

- A medical plan that has pediatric dental essential health benefits coverage, **or**
- A standalone pediatric dental essential health benefits policy (Dental Pediatric plan), **or**
- A standalone adult or family dental plan that includes pediatric dental essential health benefits coverage.

On exchange

If you're eligible for a subsidy to help pay for your health coverage and want to use it, you must get your medical plan through the state's health coverage exchange, which is an online marketplace to buy health coverage.

To learn more, visit your state's exchange website at www.connectforhealthco.com.

Off exchange

If you aren't eligible for a subsidy, or if you're shopping for a dental or vision plan, you don't have to buy through the exchange. **You can still get coverage as before, through a broker or agent, or directly from an insurance company.**

Because there are rules for plans on the exchange, you might find that plans off the exchange offer more choices.

Our off-exchange products

Anthem Blue Cross and Blue Shield (Anthem) can help you get the dental and vision care you need — which can help you get a better handle on your total health. That's why many of our dental plans include exams, cleanings and X-rays covered 100%, and all of our vision plans include coverage for yearly vision exams.

The table helps you compare your plan choices. So you have many ways to get the smile you want, and keep a healthy mouth.

	Anthem Dental Pediatric	Anthem Dental Family		Anthem Dental Family Enhanced		Dental Prime		
	Dependents age 18 and younger	*Dependents age 18 and younger*	*Adults age 19+*	*Dependents age 18 and younger*	*Adults age 19+*	*Plan A*	*Plan B*	*Plan C*
	In & out-of-network							
Diagnostic & preventive services	No waiting period	No waiting period	No waiting period	No waiting period	No waiting period	No waiting period		
Cleaning, exams, X-rays	100%/70%	100%/70%	100%/50%	100%/80%	100%/50%	100%	100%	100%
Extra cleaning	Not covered	Not covered	Not covered	Not covered	Not covered	For those who are pregnant or living with diabetes		
Basic services	No waiting period	No waiting period	6-month waiting period	No waiting period	6-month waiting period	6-month waiting period		
Fillings	60%/50%	60%/50%	50%/25%	80%/60%	80%/40%	Not covered	80%	80%
Brush biopsy	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	80%	80%
Complex & major services	No waiting period	No waiting period	No waiting period	No waiting period except cosmetic ortho 12-month	12-month waiting period	No waiting period		
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	50%/50%**	50%/50%**	30%/15%	80%/50%**	50%/25%	Not covered	50%	50%
Prosthetics (crowns, dentures, bridges)	50%/50%**	50%/50%**	30%/15%	50%/50%**	50%/25%	Not covered	Not covered	50%
Medically necessary orthodontia	50%/50%	50%/50%	Not covered	50%/50%	Not covered	Not covered	Not covered	Not covered
Cosmetic orthodontia	Not covered	Not covered	Not covered	50%/50%	Not covered	Not covered	Not covered	Not covered
Dental network	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime
Deductible (per person)	$50 (all services)	$50 (all services)	$50 (all services)	$25 (all services)	$50 (all services)	None	$50 (all services)	$50 (all services)
Yearly limit (per person)	None	None	$750	None	$1,000	$500	$1,000	$1,250
Yearly out-of-pocket limit	$350*/None	$350*/None	None	$350*/None	None	None	None	None
International emergency dental program	Included	Included		Included		Included		
Optional Blue View Vision coverage	Not available	Not available		Not available		Available		

*Per child, up to 2 children
**The coverage for pediatric children does not cover Periodontic or Prosthetic services

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

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

Individual dental and vision premiums for Colorado

Anthem BlueCross BlueShield

For policies with start dates beginning January 2015

We know that you have choices when it comes to health care coverage. Anthem Blue Cross and Blue Shield (Anthem) gives you access to complete dental coverage and one of the largest dental networks in the state. But cost is important to you, too.

Because insurance can be a big part of your budget, we make every effort to keep our costs low — so you pay less for coverage. The price you pay for your dental premium depends on several things, including how much dental care costs and where you live.

Anthem Dental Plans

With our Anthem Dental Pediatric, Anthem Dental Family and Anthem Dental Family Enhanced plans, you will not be charged premiums for more than three children, even if there are more children covered by the plan. For the Anthem Dental Family and Anthem Dental Family Enhanced plans, each dependent child ages 21-26 is rated, and then up to the three eldest children ages 0-20.

Note: The pediatric dental policy DOES NOT provide any dental benefits to individuals age nineteen (19) or older. The pediatric dental policy is offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. A person age nineteen (19) or older will need to buy a separate adult plan if they want adult dental benefits. The pediatric dental policy WILL NOT pay for any adult dental care.

Anthem Dental Pediatric

1 Child	$17.63
2 Children	$35.26
3 or more children	$52.89

Anthem Dental Family

1 Adult + 1 child	$42.95
1 Adult + 2 children	$60.17
1 Adult + 3 or more children	$77.39
2 Adults + 1 child	$68.68
2 Adults + 2 children	$85.90
2 Adults + 3 or more children[1]	$103.12

Anthem Dental Family Enhanced

1 Adult + 1 child	$66.00
1 Adult + 2 children	$92.53
1 Adult + 3 or more children	$119.06
2 Adults + 1 child	$105.47
2 Adults + 2 children	$132.00
2 Adults + 3 or more children[1]	$158.53

Dental Prime

Premiums (Annual rates reflect a 5% discount when pre-paying annually)	Plan A		Plan B		Plan C	
	Monthly	*Annual*	*Monthly*	*Annual*	*Monthly*	*Annual*
Individual	$25.10	$286.15	$42.40	$483.35	$52.70	$600.80
Individual + 1	$48.80	$556.30	$82.45	$939.95	$102.45	$1,167.95
Family	$78.10	$890.35	$131.90	$1,503.65	$163.90	$1,868.45

Blue View Vision℠

This optional vision rider is available only when purchased with Dental Prime

Premiums (Annual rates reflect a 5% discount when pre-paying annually)	Monthly	Annual
Individual	$7.20	$82.08
Individual + 1	$12.60	$143.64
Family	$20.16	$229.82

Anthem BlueCross BlueShield

1 For other combinations please talk to your broker or Sales representative.

Note: The children rates in the charts above are defined as dependent children ages 0 - 20.

Rates apply to members under age 65 and are subject to change.

As of January 1, 2014, the Affordable Care Act (ACA) or health care reform law, requires health insurers to pay an annual fee to fund premium subsidies and Medicaid expansion. This fee applies to fully insured dental and vision plans. The monthly premiums listed above include the ACA insurer fee.