HOW TO CHOOSE AND USE YOUR HEALTH PLAN

Get the answers you need with this helpful guide

Connecticut

2020 Plan Year

Health Insurance Plans for Individuals or Families

Bronze, Silver, Gold and Catastrophic plans offered by Anthem Blue Cross and Blue Shield on Access Health CT

Open Enrollment period runs
November 1, 2019 - December 15, 2019

05529CTMENABS 7/19

WHY CHOOSE ANTHEM?

When you choose an Individual Health Insurance plan for you or your family with Anthem Blue Cross and Blue Shield, you'll have access to leading doctors and hospitals. You can even have a private video visit with a doctor or therapist on your smartphone, tablet or computer. And included with every medical plan, you'll get pharmacy coverage, too.

One stop coverage for all your needs

You can easily coordinate your medical and dental coverage. It can result in better care delivered sooner and at a lower cost. Plus, preventive care is offered for as low as $0, with no copay or deductible to meet when it's received from doctors in your plan.

Trusted brand name

One in three Americans carries a Blue branded card, which is accepted by providers, such as doctors and hospitals, across the country.[1]

Local presence

Our families live and work here – and we've been committed to improving the health of Connecticut residents like you since 1936.

We understand your needs are unique

That's why we offer health plan choices to help you be your best. We also have many extra benefits you may not be aware of. Take a look.

Convenient options for care:

- With **LiveHealth Online**, you can visit a board certified doctor, psychologist, or therapist using your smartphone, tablet, or computer with a webcam - in both English and Spanish. Doctors are available 24/7 to assess your condition and if it's needed, they can send a prescription to your local pharmacy.[2]
- With **24/7 NurseLine**, you can call a registered nurse with your health questions or concerns any time, day or night. You can also use the toll free line to access an AudioHealth Library.
- Get personalized information about your health plan through the **Sydney mobile app** or **anthem.com**. Self service tools allow you to see your claims and coverage details, refill prescriptions, estimate the costs of common procedures, make monthly premium payments and much more.

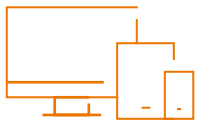
MyHealth Advantage

This program tracks your health and pharmacy claims to see if there are any gaps in care or ways to save money. If so, you get a personalized, confidential MyHealth Note in the mail. You can also download the Sydney mobile app to receive your MyHealth Notes electronically through the Mobile Inbox.

1 https://www.bcbs.com/sites/default/files/file-attachments/page/Blue_Facts_Sheet-2019.pdf

2 Prescription availability is defined by physician judgment and state regulations. LiveHealth Online is the trade name of Health Management Corporation. Visit livehealthonline.com to learn more.

TABLE OF CONTENTS



QUICK CLICKS

Get the info you want now. Just pick a topic to take you right to that section.

- Health care plans
- Networks (doctors in your plan)
- Find a Doctor
- Prescriptions

WHAT YOU NEED TO KNOW TO CHOOSE A PLAN

YOUR OPTIONS FOR COVERAGE

Medical plans

Our individual and family health insurance plans give you lots of options. You'll get preventive care, such as screenings and flu shots, for as low as $0, with no copay from **in-network** doctors (doctors in your plan). Plus, you won't have to meet your deductible first. And you'll have the health insurance you need in case of an emergency or illness.

Dental/Vision

Connecting dental and vision coverage to your medical plan is important to overall health.

- 90% of the body's diseases first show signs and symptoms in the mouth[1]
- 1 in 5 cases of tooth loss is linked to diabetes[2]
- 22 of the top 25 prescribed medications can have an impact on vision[3]

Essential pediatric vision benefits are included with our medical plans.[4] Anthem knows how important both dental and vision care is to overall health, so we also offer stand-alone plans to you and your family with great care from leading doctors. When you have medical, dental and vision coverage through Anthem, we connect all of your providers with Anthem Whole Health Connection®. It's a program that helps improve your member experience by focusing on your whole person health.

Pharmacy

Our health plans include coverage for prescription drugs. Did you know that pharmacy is the most widely used benefit – 4x more than medical?† Getting the most out of your pharmacy benefits can help keep you healthy and save you money.

Manage your drug costs:
Your plan includes coverage for hundreds of brand and generic drugs. You can save money by talking to your doctor about lower cost alternatives. To see if your drug is covered, go to anthem.com/pharmacyinformation and choose the **Connecticut Select Drug List**.

Fill your prescription the way you choose:

- **Retail Pharmacies**
  Your pharmacy network includes nearly 70,000 retail pharmacies nationwide including well-known chains like CVS, Walmart, Costco and Kroger. To see if your pharmacy is in the plan's network, visit anthem.com/pharmacyinformation/rxnetworks.html.
- **Home Delivery**
  With home delivery, you can get up to a 90-day supply of your maintenance medications - drugs used to treat long-term conditions like high blood pressure or diabetes - **delivered right to your door!** By using our home delivery pharmacy, you're more likely to follow your drug treatment plan resulting in better health outcomes.◊

1 Academy of General Dentistry Know Your Teeth website: Warning Signs in the Mouth Can Save Lives (accessed August 2019); knowyourteeth.com

2 https://www.mouthhealthy.org/en/az-topics/d/diabetes

3 Anthem analysis of top utilized drugs and the side effects as described in Lippincott Drug Guide for Nurses, 2018

4 Adult vision coverage are not considered essential health benefits under ACA plan guidelines and offered directly from Anthem

† Ambulatory Care Use and Physician office visits, US Centers for Disease Control and Prevention (accessed 2/16/2017. Retail Prescription Drugs Filled at Pharmacies (Annual per Capita) (accessed 2/16/2017): kff.org

◊ Schwab P, Racsa P, Rascati K, Mourer M, Meah Y, Worley K. A Retrospective Database Study Comparing Diabetes-related Medication Adherence and Health Outcomes for Mail-order versus Community Pharmacy. J Manag Care Spec Pharm 2019 Mar;25(3):332-40: ncbi.nlm.nih.gov/pubmed/30816817.

MORE OPTIONS FOR COVERAGE THROUGH ANTHEM

Term Life Insurance

Anthem Life Insurance Company now offers low cost term life insurance coverage. Our Individual term life plans include two coverage options: $25,000 and $50,000. You can choose the coverage amount that fits your needs. Life insurance is an important decision, but it doesn't have to be a complicated one. Term Life Insurance underwritten by Anthem Life Insurance Company. Information about this coverage can be found at anthem.com.

Additional Coverage

For additional coverage or for the unexpected, you have choices. There are a variety of plans that offer coverage for accidents and hospital stays available from LifeSecure™*. While these are not Affordable Care Act-compliant plans, they offer reasonably priced coverage for specific benefits. And, when paired with an Anthem health plan, these plans can provide more complete coverage and better financial protection. A representative can help you with additional coverage options from LifeSecure to fit your needs. Information about this coverage can be found at anthem.com.

TO LEARN MORE

You can also see and compare plans online at anthem.com. If you'd like a paper copy of this information by fax or mail, call Anthem or your licensed broker.

* LifeSecure Insurance Company ("LifeSecure") underwrites and has sole financial responsibility for the Accident and Hospital Recovery insurance products. LifeSecure is an independent company and there is no ownership affiliation between LifeSecure and Anthem Blue Cross and Blue Shield. LifeSecure products do not offer qualifying health coverage ("Minimum Essential Coverage" or "MEC") that satisfies the health coverage under the Affordable Care Act. The termination or loss of one of these policies does not entitle you to a Special Enrollment Period to purchase a health benefit plan that qualifies as MEC outside of an Open Enrollment Period.

ANSWERS TO YOUR QUESTIONS

WHY DO I NEED COVERAGE?

The short answer is ... life happens and it helps to be ready. No one plans to break an arm or catch pneumonia. That's why having a health care plan is so important. It helps you:

- Pay for those unexpected costs that come with a serious illness or injury.
- Get some important benefits like preventive care that can help you stay healthier and get more effective treatment.

Still not convinced? Here are three reasons why coverage is so important:

1. **It's worth the price.** Have you ever thought about what the cost would be to have a major surgery without health insurance? Now picture adding that in with your mortgage/rent and monthly expenses. That's a case where monthly payments for coverage are small compared to footing the bill for a major unexpected cost.

2. **It helps you stay on top of checkups.** When you have coverage, you'll be much more likely to use it to get your yearly checkups and tests that can catch issues early. Plans even include preventive care at no extra cost when you use doctors in your plan (in-network doctors).

3. **It's an investment in you.** You insure your home and cars, so why would you put yourself at the bottom of the list? Think about how much it would cost to fix you if something serious were to happen.

HOW DO I CHOOSE A PLAN?

Choosing the right plan for you can be a challenge. We get that. So let's start with some questions to figure out what works best for you:

- How often do you see doctors and specialists?
- What prescription medications do you take regularly?
- Are you planning any procedures this year?

See Find a Doctor instructions, Pharmacy coverage details and read about the plan choices below to see which plan best fits your needs.

Plan choices

Metal Levels

- **Bronze:** You'll have lower monthly payments while being covered for check ups and preventive care. You could pay more out of pocket if you need more care, but if you don't expect to go to the doctor very much this year, Bronze may be a good bet. These health plans can be great for people who are younger with no dependents.
- **Silver:** You'll get health coverage that covers all the basics and more. You'll also get preventive care for $0 with no copay and no deductible from in-network doctors.
- **Gold:** You'll have higher monthly payments but lower out of pocket costs depending on the services you use. You'll also have a lower deductible to meet, and you can save on visits to doctors or specialists when you need them.
- **Catastrophic:** If you're under age 30 (or are 30 or older with an approved hardship exemption from the Health Insurance Marketplace) you may qualify for a high-deductible, lower monthly payment, Catastrophic plan. Catastrophic plans can help protect you from worst-case scenarios like serious accidents or illnesses.

ANSWERS TO YOUR QUESTIONS

CAN I AFFORD IT?

If you're thinking coverage might cost too much, you're not alone. But, what you might not know is that you may be able to get help paying for it. And a health insurance subsidy may be the answer. Don't know what a subsidy is? That's just a fancy word for getting financial help from the government to help you pay for your health care coverage.

You could be eligible for a premium subsidy, also called an advanced premium tax credit, to lower your monthly payment. You may also qualify for a Silver Cost Sharing Reduction (CSR) plan where you'll pay less for your out-of-pocket costs. Silver CSR Plans are only available through Access Health CT, and enrollment is limited to those individuals with qualifying income levels based on income and household size. Please visit accesshealthct.com to find out if you are eligible for a premium subsidy or if you are eligible to enroll in a Silver CSR Plan, which can reduce the amount you have to pay out of pocket for essential health benefits.

Other ways to help save money:

- Check if your favorite doctor, hospital or other health care provider is in your plan. That way you can make sure you get your care at the lower or negotiated network rate. Check provider participation through Access Health CT or through Anthem's Find a Doctor tool.
- You can also save money by only using the emergency room (ER) for emergencies. Head straight to the ER or call 911 for serious health issues. Otherwise, save yourself money and time by visiting your primary care doctor, an urgent care center, or LiveHealth Online for minor medical issues.
- Consider purchasing an Anthem tiered plan where you get the same great access to every doctor and hospital in our network, and the same preventive care benefits and where you save on out-of-pocket costs for both primary and select specialist care when you choose a Value Tier 1 doctor in our network.

TO LEARN MORE

You can also see and compare plans online at anthem.com or accesshealthct.com. If you'd like a paper copy of this information by fax or mail, call Anthem or your licensed broker.

ANSWERS TO YOUR QUESTIONS

HOW DO I FIND A DOCTOR OR HOSPITAL?

You can find an in-network doctor, hospital, dentist, pharmacy and more by using our **Find a Doctor** tool.[1] It's quick and easy. Plus, you'll get the most from your health care coverage (and save money), if you choose a doctor or hospital in your plan. Follow these simple steps:

1. Go to **anthem.com**.
2. Select **Find a Doctor** at the top right of your screen.
3. Scroll past **Search as a Member** to **Search as Guest**.
4. Choose **Search by Selecting a Plan or Network** and complete the form.

The difference between doctors in the plan and doctors outside the plan

Doctors in the plan:	Doctors and other health care providers who contract with us to provide care at discounted rates.
Doctors outside the plan:	Doctors and other health care providers who are not contracted with the health plan.

NEW! Anthem members can now get quality in-network primary care, urgent care walk-ins, lab and imaging tests all in one place—at Sanitas Medical Centers. With locations in Bridgeport, Hartford and Newington, Sanitas gives you the convenience of same-week appointments, with bilingual teams who spend as much time as you need. It's a personalized whole-family approach that will leave you feeling cared for. Go to **mysanitas.com/anthem** for more information.*

WHAT SHOULD I KNOW ABOUT MY NETWORK?

Depending on what type of plan you choose, your benefits, doctor and medical facility choices may be different:

- **Preferred provider organization (PPO):** When you enroll in our PPO plan, you'll need to pick a primary care doctor (PCP); however, you don't need to get a referral from your selected PCP before seeking other care. PCPs can coordinate care. Plus, members who have a relationship with a PCP have been shown to have fewer preventable emergency room visits and hospital admissions than those who don't.* PPOs offer coverage for both in-network and out-of-network, in-state providers — though you'll save more when you see doctors in your plan. Be sure to check our Find a Doctor tool to confirm your doctor is still in your plan. If you get non-emergency care outside of Connecticut, you'll only be covered by your Anthem plan at the out-of-network benefit level.
- **Health maintenance organization (HMO):** Similar to our PPO, with our HMO, you must pick a primary care doctor, and you don't need referrals to see specialists. However, HMOs don't offer out-of-network benefits, except for emergency and urgent care or when a service is preapproved. If you see a doctor not in the plan for any other reason, you'll have to pay 100% out of pocket.
- **Tiered network:** Our Pathway Enhanced Tiered network includes in-network tiered benefits that are split into two categories: Value Tier 1 and Participating Tier 2. You pay a lower cost share for doctors and hospitals in Value Tier 1. Many *Value Tier 1* doctors also commit to a higher level of support for Anthem members that can include the help of a patient navigator, expedited appointment scheduling, telehealth services and specialty E-consult access through your primary care physician. To see what tier a doctor or hospital is in, visit the **Find a Doctor** tool at **anthem.com/findadoctor –** look for "Value Tier 1" or "Participating Tier 2".

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

* Sanitas is an independent Medical Center.

MEMBER ADVANTAGES

Making informed health care decisions for you and your family is simple with our website, mobile app and online care options.

ONLINE TOOLS

No matter which plan you choose, you can register at anthem.com or on the Sydney mobile app to get personalized information about your health plan all in one place.

Use the self-service tools on our secure website to:

- See your claims and coverage details.
- Estimate your costs on common procedures, before you step into the doctor's office.
- Manage your prescription benefits and search the drug list that applies to your plan.
- Check the price of a drug or refill a prescription.
- Make your monthly payments online.

With our Sydney mobile app, you can:

- Find a nearby doctor, specialist, urgent care center or hospital.
- Download a virtual member ID card.
- Manage your prescription drug benefits.

CONVENIENT ONLINE CARE

Have a private video visit with a board-certified doctor or licensed therapist through LiveHealth Online.

LiveHealth Online

- No need to sit in a waiting room or even leave home for non-emergencies.

Talk to a doctor whenever, wherever with LiveHealth Online	LiveHealth Online Psychology offers virtual counseling
Easy: Connect to a doctor 24 hours a day, from a computer, tablet, or smartphone with a webcam. **Face-to-face:** Chat by two-way video for common health issues, like a cold, the flu, allergies and more. **Save:** On average members save on care, compared to ER, urgent care, or other health facilities.	**Convenient:** Visits available from 7 a.m. to 11 p.m., coast-to-coast. **Quick access:** Schedule a visit and be seen within four days, or on demand, when available. **Same cost:** Cost-share is the same as it is for in-office Mental Health/Substance Use therapy benefits.

MEMBER ADVANTAGES

PLANS INCLUDE OTHER FEATURES TO HELP YOU AND YOUR FAMILY STAY HEALTHY AT NO ADDITIONAL COST

- **24/7 Nurseline:** Our registered nurses can answer your health questions wherever you are – any time, day or night. All you have to do is call.
- **Care Support:** If you need extra care for ongoing or complex health issues, a case manager may call you. Your case manager can answer your questions, set up care with different doctors and help you use your health benefits.
- **MyHealth Advantage:** Avoid health issues, stay healthy and save money. This program tracks your health information to see if there's anything you can do to improve your health. If so, you'll get a personalized and confidential MyHealth Note in the mail.

PEACE OF MIND WHEN YOU TRAVEL

Whether you're traveling for work or on vacation, going to the ER or urgent care is the last thing you want to worry about. The good news is you don't have to! All of our plans cover medically necessary emergency and urgent care in all 50 states, even when you're not using your plan's doctors and hospitals.

SIMPLIFIED PAYMENTS

We know life gets busy, so we're making it easier for you to pay your monthly payments.

- Set up electronic funds transfer (EFT) or bank draft.
- Enroll in WebPay to use with a Visa or MasterCard debit or credit card.
- Download our Sydney mobile app and pay with a credit card or your bank account. You can even set up autopay in the app.

You can set up automatic monthly payments with each option. Just make sure your card account information and expiration date stays up to date.

SPECIAL SAVINGS FROM SPECIALOFFERS[1]

Members can get discounts on products and services, including vitamins, weight loss support, glasses and contacts, sports gear and fitness club memberships, that help promote better health and wellbeing. **You can even get a 20% discount on a 23andME® Ancestry kit and $40 off each Health + Ancestry kit.**

1 SpecialOffers discounts are subject to change without notice.

PLAN BENEFIT CHARTS

PPO plans also include out-of-network benefits. **HMO** plans only include out-of-network benefits for emergency care, urgent care and ambulance services. Cost share may vary based on where you receive care. Individual deductible, Individual out-of-pocket limit and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information is for in-network services only. These plans are certified by and offered through Access Health CT at accesshealthct.com.

	Bronze PPO Standard Pathway X for HSA (4F96)	**Bronze PPO Standard Pathway X (4F9N)**	**Bronze PPO Pathway X (4G78)**
Network name	Pathway X	Pathway X	Pathway X
Plan includes out-of-network coverage?	Yes	Yes	Yes
Individual deductible[1]	$5,685 / $9,200 (Family = 2x individual amt) In-network / Out-of-network	$6,200 / $12,400 (Family = 2x individual amt) In-network / Out-of-network	$6,500 / $15,000 (Family = 2x individual amt) In-network / Out-of-network
Individual out-of-pocket limit	$6,550 / $12,900 (Family = 2x individual amt) In-network / Out-of-network	$8,150 / $16,300 (Family = 2x individual amt) In-network / Out-of-network	$8,150 / $20,000 (Family = 2x individual amt) In-network / Out-of-network
Coinsurance (percentage may vary for some covered services)	10% / 50% In-network / Out-of-network	0% / 50% In-network / Out-of-network	50% / 50% In-network / Out-of-network
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 10% coinsurance	$40 copay	$30 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 10% coinsurance	Deductible, then $60 copay	Deductible, then $70 copay
Office visit: LiveHealth Online web visit	Deductible, then 10% coinsurance	$40 copay	$10 copay
Diagnostic tests[2] (Ex. X-ray, EKG)	Deductible, then 10% coinsurance	Deductible, then $40 copay	Deductible, then 50% coinsurance
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	Deductible, then 10% coinsurance	Deductible, then $75 copay	Deductible, then 50% coinsurance
Urgent care	Deductible, then 10% coinsurance	$75 copay	$75 copay
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 10% coinsurance	Deductible, then $450 copay	Deductible, then 50% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 10% coinsurance	Deductible, then $500 copay per day up to 2 days per admission	Deductible, then 50% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 10% coinsurance	Deductible, then $500 copay	Deductible, then 50% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2, 3, 4: Medical deductible applies	Tier 1: No deductible Tiers 2, 3, 4: Medical deductible applies	Tier 1: No deductible Tiers 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]	10% coinsurance	$10 copay	$5 copay
Retail pharmacy tier 2[4]	15% coinsurance	50% coinsurance	$50 copay
Retail pharmacy tier 3[4]	25% coinsurance	50% coinsurance	50% coinsurance (up to $500 per script)
Retail pharmacy tier 4	30% coinsurance (up to $500 per script)	50% coinsurance (up to $500 per script)	50% coinsurance (up to $750 per script)
Physical and occupational therapy (limits apply)	Deductible, then 10% coinsurance	Deductible, then $30 copay	Deductible, then $30 copay

Please see Medical and Silver cost-sharing reduction plans footnotes on page 15.

PLAN BENEFIT CHARTS

PPO plans also include out-of-network benefits. **HMO** plans only include out-of-network benefits for emergency care, urgent care and ambulance services. Cost share may vary based on where you receive care. Individual deductible, Individual out-of-pocket limit and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information is for in-network services only. These plans are certified by and offered through Access Health CT at accesshealthct.com.

	Bronze HMO Pathway X Enhanced Tiered (4F9S)[Δ]	**Silver PPO Standard Pathway X (4F98)**	**Gold PPO Standard Pathway X (4F9F)**
Network name	Pathway X Enhanced Tiered	Pathway X	Pathway X
Plan includes out-of-network coverage?	No	Yes	Yes
Individual deductible[1]	Tier 1: $5,900 (Family = 2x individual amt) Tier 2: $7,900 (Family = 2x individual amt)	$4,300 / $8,600 (Family = 2x individual amt) In-network / Out-of-network	$1,300 / $3,000 (Family = 2x individual amt) In-network / Out-of-network
Individual out-of-pocket limit	$8,150 (Family = 2x individual amt)	$8,150 / $16,300 (Family = 2x individual amt) In-network / Out-of-network	$5,250 / $10,500 (Family = 2x individual amt) In-network / Out-of-network
Coinsurance (percentage may vary for some covered services)	Tier 1: 0% Tier 2: 50%	0% / 40% In-network / Out-of-network	0% / 30% In-network / Out-of-network
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	Tier 1: $40 copay Tier 2: Deductible, then 50% coinsurance	$40 copay	$20 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Tier 1: Deductible, then $70 copay Tier 2: Deductible, then 50% coinsurance	$60 copay	$40 copay
Office visit: LiveHealth Online web visit	$20 copay	$40 copay	$20 copay
Diagnostic tests[2] (Ex. X-ray, EKG)	Tier 1: Deductible, then $40 copay Tier 2: Deductible, then 50% coinsurance	Deductible, then $40 copay	Deductible, then $40 copay
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	Tier 1: Deductible, then $75 copay Tier 2: Deductible, then 50% coinsurance	$75 copay	$65 copay
Urgent care	$75 copay	$75 copay	$50 copay
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 50% coinsurance	Deductible, then $450 copay	$400 copay
Hospital: inpatient admission (includes maternity, mental health / substance use)	Tier 1: Deductible, then $750 copay per day up to 2 days per admission Tier 2: Deductible, then 50% coinsurance	Deductible, then $500 copay per day up to 4 days per admission	Deductible, then $500 copay per day up to 2 days per admission
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Tier 1: Deductible, then $500 copay Tier 2: Deductible, then 50% coinsurance	Deductible, then $500 copay	Deductible, then $500 copay
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Tier 1: No deductible Tiers 2, 3, 4: Medical deductible applies	Tier 1: No deductible Tiers 2, 3, 4: $250 Combined pharmacy deductible	Tiers 1, 2, 3: No deductible Tier 4: $50 Pharmacy deductible
Retail pharmacy tier 1[4]	$10 copay	$10 copay	$5 copay
Retail pharmacy tier 2[4]	50% coinsurance	$45 copay	$35 copay
Retail pharmacy tier 3[4]	50% coinsurance (up to $500 per script)	$70 copay	$60 copay
Retail pharmacy tier 4	50% coinsurance (up to $750 per script)	20% coinsurance (up to $200 per script)	20% coinsurance (up to $100 per script)
Physical and occupational therapy (limits apply)	Deductible, then $30 copay	$30 copay	$20 copay

Please see Medical and Silver cost-sharing reduction plans footnotes on page 15.

PLAN BENEFIT CHARTS

PPO plans also include out-of-network benefits. **HMO** plans only include out-of-network benefits for emergency care, urgent care and ambulance services. Cost share may vary based on where you receive care. Individual deductible, Individual out-of-pocket limit and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information is for in-network services only. These plans are certified by and offered through Access Health CT at accesshealthct.com.

	Gold PPO Pathway X (4FB7)	**Gold HMO Pathway X Enhanced Tiered (4FA5)[Δ]**	**Catastrophic HMO Pathway X Enhanced (4F9A)[◊]**
Network name	Pathway X	Pathway X Enhanced Tiered	Pathway X Enhanced
Plan includes out-of-network coverage?	Yes	No	No
Individual deductible[1]	$2,000 / $6,000 (Family = 2x individual amt) In-network / Out-of-network	Tier 1: $1,750 (Family = 2x individual amt) Tier 2: $3,000 (Family = 2x individual amt)	$8,150 (Family = 2x individual amt)
Individual out-of-pocket limit	$8,150 / $12,000 (Family = 2x individual amt) In-network / Out-of-network	$8,150 (Family = 2x individual amt)	$8,150 (Family = 2x individual amt)
Coinsurance (percentage may vary for some covered services)	20% / 50% In-network / Out-of-network	Tier 1: 10% Tier 2: 30%	0%
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$30 copay	Tier 1: $30 copay Tier 2: Deductible, then 30% coinsurance	$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then $60 copay	Tier 1: Deductible, then $60 copay Tier 2: Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Office visit: LiveHealth Online web visit	$10 copay	$10 copay	$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance
Diagnostic tests[2] (Ex. X-ray, EKG)	Deductible, then 20% coinsurance	Tier 1: Deductible, then 10% coinsurance Tier 2: Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	Deductible, then 20% coinsurance	Tier 1: Deductible, then 10% coinsurance Tier 2: Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Urgent care	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 0% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 20% coinsurance	Tier 1: Deductible, then 10% coinsurance Tier 2: Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 20% coinsurance	Tier 1: Deductible, then 10% coinsurance Tier 2: Deductible, then 30% coinsurance	Deductible, then 0% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]	$5 copay	$5 copay	0% coinsurance
Retail pharmacy tier 2[4]	$60 copay	$60 copay	0% coinsurance
Retail pharmacy tier 3[4]	50% coinsurance (up to $500 per script)	50% coinsurance (up to $500 per script)	0% coinsurance
Retail pharmacy tier 4	50% coinsurance (up to $750 per script)	50% coinsurance (up to $750 per script)	0% coinsurance
Physical and occupational therapy (limits apply)	$30 copay	$30 copay	Deductible, then 0% coinsurance

Please see Medical and Silver cost-sharing reduction plans footnotes on page 15.

SILVER COST-SHARING REDUCTION (CSR) PLANS

Cost share may vary based on where you receive care. To see if you qualify for a premium tax credit subsidy or a Silver 73%, 87%, or 94% cost sharing reduction plan (CSR) that you can only buy through Access Health CT, please go to accesshealthct.com.

	Silver PPO Standard Pathway X (4F98)	Silver PPO Standard Pathway X 73% CSR (4F9E)	Silver PPO Standard Pathway X 87% CSR (4F9B)	Silver PPO Standard Pathway X 94% CSR (4F9Q)
Network name	Pathway X	Pathway X	Pathway X	Pathway X
Plan includes out-of-network coverage?	Yes	Yes	Yes	Yes
Individual deductible[1]	$4,300 / $8,600 (Family = 2x individual amt) In-network / Out-of-network	$3,950 / $8,600 (Family = 2x individual amt) In-network / Out-of-network	$650 / $8,600 (Family = 2x individual amt) In-network / Out-of-network	$0 / $8,600 (Family = 2x individual amt) In-network / Out-of-network
Individual out-of-pocket limit	$8,150 / $16,300 (Family = 2x individual amt) In-network / Out-of-network	$6,500 / $16,300 (Family = 2x individual amt) In-network / Out-of-network	$2,500 / $16,300 (Family = 2x individual amt) In-network / Out-of-network	$900 / $16,300 (Family = 2x individual amt) In-network / Out-of-network
Coinsurance (percentage may vary for some covered services)	0% / 40% In-network / Out-of-network	0% / 40% In-network / Out-of-network	0% / 40% In-network / Out-of-network	0% / 40% In-network / Out-of-network
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$40 copay	$40 copay	$20 copay	$10 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	$60 copay	$60 copay	$45 copay	$30 copay
Office visit: LiveHealth Online web visit	$40 copay	$40 copay	$20 copay	$10 copay
Diagnostic tests[2] (Ex. X-ray, EKG)	Deductible, then $40 copay	Deductible, then $40 copay	Deductible, then $30 copay	$25 copay
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	$75 copay	$75 copay	$60 copay Covered up to a combined annual max of $360 for MRI and CAT scans; $400 for PET scans	$50 copay Covered up to a combined annual max of $350 for MRI and CAT scans; $400 for PET scans
Urgent care	$75 copay	$75 copay	$35 copay	$25 copay
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then $450 copay	Deductible, then $450 copay	Deductible, then $150 copay	$50 copay
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then $500 copay per day up to 4 days per admission	Deductible, then $500 copay per day up to 4 days per admission	Deductible, then $100 copay per day up to 4 days per admission	$75 copay per day up to 4 days per admission
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then $500 copay	Deductible, then $500 copay	Deductible, then $100 copay	$75 copay
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Tier 1: No deductible Tiers 2, 3, 4: $250 Combined pharmacy deductible	Tier 1: No deductible Tiers 2, 3, 4: $250 Combined pharmacy deductible	Tiers 1, 2: No deductible Tiers 3, 4: $50 Combined pharmacy deductible	Tiers 1, 2, 3, 4: No deductible
Retail pharmacy tier 1[4]	$10 copay	$10 copay	$10 copay	$5 copay
Retail pharmacy tier 2[4]	$45 copay	$45 copay	$25 copay	$10 copay
Retail pharmacy tier 3[4]	$70 copay	$70 copay	$40 copay	$30 copay
Retail pharmacy tier 4	20% coinsurance (up to $200 per script)	20% coinsurance (up to $100 per script)	20% coinsurance (up to $60 per script)	20% coinsurance (up to $60 per script)
Physical and occupational therapy (limits apply)	$30 copay	$30 copay	$20 copay	$20 copay

Please see Medical and Silver cost-sharing reduction plans footnotes on page 15.

MEDICAL AND SILVER COST-SHARING REDUCTION PLANS BENEFIT FOOTNOTES

1 The medical plan charts display the **individual deductible**. Family deductibles are two (2) times the individual amount for most plans.

2 Cost shares listed for **Diagnostic tests** and **Advanced diagnostic tests** reflect services received in an outpatient setting. **Advanced diagnostic imaging** is covered at your copay amount per service with an annual max of up to $375 for CAT Scans and MRIs and $400 for PET Scan when rendered at outpatient settings. If these services are performed by other providers, the cost share may be higher for the plan. Please see the for details.

3 For plans with a **Pharmacy deductible**, the pharmacy deductible is separate from the medical deductible. The family deductible is 2 times the individual amount.

4 Home delivery pharmacy cost shares are 2 times the retail copay for Tier 1 drugs and 2.5 times the retail copay for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays.

◊ Available if you are under age 30 before the plan's effective date; or have received certification from Access Health CT that you are exempt from the individual mandate because you qualify for a hardship exemption or don't have an affordable coverage option.

NOTE:

The Tier 1 network includes Primary Care Providers, acute general Hospitals, and Specialists in certain specialist categories such as Cardiology, Endocrinology, Obstetrics and Gynecology, and Orthopedic Surgery. To see which tier a doctor or hospital is in, visit the Find a Doctor tool at anthem.com/findadoctor and look for "Value Tier 1" or Participating Tier 2.

EMBEDDED PEDIATRIC VISION BENEFITS DETAILS

The following vision care services are covered for members until the end of the month in which they turn 19. Coverage may include eye exams, eye glass lenses, frames and contact lenses. The benefit period is the calendar year (January 1 through December 31).

- If you purchase a Catastrophic plan, you must meet your medical deductible before pediatric vision benefits are paid.
- Out-of-network providers may bill you for any charges that exceed the plan's maximum allowed amount.
- Out-of-network pediatric vision benefits displayed only apply if the medical plan provides for out-of-network coverage.

	Benefit frequency	Cost share *in-network*
Eye exam	Once every benefit period	$0 copay up to maximum allowed amount
Lenses (single, biofocal, trifocal and standard progressive)	Once every benefit period	$0 copay up to maximum allowed amount
Frames	Once every benefit period	Anthem formulary[1]
Contact lenses (Non-elective)	Once every benefit period[2]	Covered in full
Contact lenses (Elective/disposable)	Once every benefit period[2]	Anthem formulary[1]

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

UNDERSTANDING INSURANCE TERMS

Let's take a look at some common insurance terms you probably see a lot.

HERE'S WHAT THEY MEAN:

Coinsurance

Your percentage of the costs. After you meet your deductible, this is your percentage of costs each time you get care and then your plan covers the rest up to the maximum allowed amount. In-network providers agree to accept Anthem's maximum allowed amount as their charge.

Copay

This is a set dollar amount you pay for covered services, such as doctor visits. The amount can vary based on covered service. It's listed in your medical plan charts.

Deductible

This is the set dollar amount you pay before we begin paying for most covered health services you receive. It's listed in your benefit plan. In-network covered preventive services don't require a deductible. Your deductible applies to the calendar year (January 1 through December 31), even if your effective date (the date coverage begins) is later than January 1.

Drug tiers

Drugs on a drug list or formulary are typically arranged in tiers. Your cost depends on which drug tier your drug is in.

In-network coverage

This refers to doctors, hospitals, dentists, pharmacies and other care providers who are part of the plan's network or are in the plan. HMO plans only include coverage for in-network benefits, except for emergency and urgent care, ambulance services, or when a service is pre-approved.

Out-of-network coverage

This refers to doctors, hospitals, dentists, pharmacies and other care providers who don't participate in the plan or network. HMO plans don't offer out-of-network benefits, except for emergency and urgent care, ambulance services, or when a service is pre-approved.

Out-of-pocket limit

This is the maximum amount you can pay out of your pocket for covered services each year. Once you reach that limit, which varies by plan, we cover the rest up to the maximum allowed amount. In-network providers agree to accept Anthem's maximum allowed amount as their charge.

Plan name

Plan name and contract code are found on the first row of the medical plan charts. Look for this when you're applying for a plan. The contract code is in parentheses after the plan name.

READY TO ENROLL? LET'S MAKE IT HAPPEN.

HELP IS CLOSE AT HAND:

Call Anthem or your licensed broker to enroll or learn more about our health care plans; **or**

Find our plans through the Access Health CT at **accesshealthct.com**.

You can buy health care plans once a year through an open enrollment period. This year, the open enrollment period runs from **November 1, 2019 - December 15, 2019**. Be sure to enroll by December 15, 2019, to start coverage effective January 1, 2020.

You may be able to change your health coverage outside of this open enrollment period if there are special qualifying events. Check with your licensed broker to see if you qualify or if you have other questions about eligibility.

WE WANT YOU TO BE SATISFIED

After you enroll in one of our plans, you'll have access to your Subscriber Agreement that explains the terms and conditions of coverage, including exclusions and limitations. You'll have 10 days to examine your Subscriber Agreement's features. If you're not fully satisfied during that time, you may cancel your coverage and your premium will be refunded, minus any claims that were already paid.

SUMMARY OF BENEFITS AND SERVICES

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

Review the Subscriber Agreement.

Call Anthem or your licensed broker

Go to anthem.com.

To receive and review a ***Summary of Benefits and Coverage (SBC)*** in English or Spanish, please visit **sbc.anthem.com** and select **NEXT**. Other languages links are listed on the SBC page below **NEXT**. You may also view a SBC at accesshealthct.com. Simply click Link to Summary within the Plan Details of a selected plan.

Anthem Health Plans, Inc. is a Qualified Health Plan issuer that offers individual health plans through Access Health CT.

IN COMPLIANCE WITH THE ACA, THE FOLLOWING PLAN CHANGES MAY OCCUR ANNUALLY ON JANUARY 1

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

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

IMPORTANT LEGAL INFORMATION

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

Eligibility

You can apply for coverage for yourself or with your family. You must be a United States citizen or a lawfully present non-citizen and a legal resident of the State of Connecticut and not be enrolled in Medicare Parts A/B and/or D. Family health coverage includes you, your spouse or domestic partner and any dependent children. Children are covered to the end of the plan year in which they turn age 26.

Eligibility for a catastrophic plan

You are eligible for this plan if you:

- are also under age 30 before the plan's effective date; or
- have received certification from Access Health CT that you are exempt from the individual mandate because you qualify for a hardship exemption or don't have an affordable coverage option

Open enrollment

As established by the rules of Access Health CT, individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period.

American Indians are authorized to move from one QHP to another QHP once per month.

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.

Effective date of coverage

The earliest effective date for the annual open enrollment period is the first day of the following benefit period for a Qualified Individual who has made a QHP selection during the annual open enrollment period. Except where noted otherwise, the applicant's effective date is determined by Access Health CT based on the receipt of the completed enrollment form.

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

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

Utilization review

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

Reviewing where services are provided

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

Examples include, but are not limited to:

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

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

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

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

The concurrent review (done during medical care and recovery)

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

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

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

IMPORTANT LEGAL INFORMATION

Case management

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

Precertification

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

Here's how getting precertification can help you out:

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

Saving money. Paying only for medically necessary services helps everyone save. Choosing a doctor who'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 prior authorization or call us to ask. The doctor's office will ask for prior authorization for you. Plus, costs are usually lower with an in-network doctor. If you choose an out-of-network provider, be sure to call us to get prior authorization. Out-of-network providers may not do that for you. Once you're a member, if you have a question about prior authorization, you can call the Member Service number on the back of your ID card.

In-network providers

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

Services you obtain from any provider other than a PCP, SCP or another in-network provider are considered an out-of-network service, except for emergency care or urgent care or ambulance services related to an emergency for transportation to a hospital or urgent care center services received at an urgent care center, or as an authorized service.

Tiered Plans have two levels of in-network benefits. Value tier 1 Facilities, have a lower Cost-Share than Participating tier 2 in-network Facilities. Provider Finder identifies providers "Value Tier 1" or "Participating Tier 2". This information appears directly under the name of the physician or facility.

Out-of-network providers

For HMO plans, services will not be covered services if rendered by providers located in the state of Connecticut unless:

- The services are for emergency care, urgent care or ambulance services related to an emergency for transportation to a hospital or urgent care services received at an urgent care center, as specified in the Subscriber Agreement; 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 an out-of-network service. The only exceptions are emergency care and urgent care or ambulance services related to an emergency for transportation to a hospital or urgent care services received at an urgent care center. In addition, certain services are not covered unless obtained from an in-network provider; see your Schedule 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 are responsible for:

- The difference between the actual charge and the maximum allowed amount plus any deductible and/or copayments/coinsurance;
- Services that are not medically necessary;
- Non-covered services;
- Filing claims;
- Higher cost-sharing amounts

Laws and rights that protect you

As a member, you have rights and responsibilities. You have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. You also have certain rights and responsibilities when receiving your health care. Visit this link to find more information on our website: http://www.anthem.com/health-insurance/customer-care/faq

Limitations

The specific limitations are spelled out in the terms of the particular plan, but some of the more common services limited by these plans are:

- Autism – Behavioral therapy for children up to 21st birthday
- Chiropractic – 20 visits per member per year
- Hearing aids – 1 hearing aid per member per ear every 24 months
- Home health care – 100 visits per member per year, combined visit limit for in-network and out-of-network
- Skilled nursing facility – 90 days per member per calendar year

IMPORTANT LEGAL INFORMATION

- Therapy services (visit limits are separate for rehabilitation and habilitation) – 40 combined visits per member per calendar year for physical, occupational and speech therapy
- Transplants – per transplant
  - Unrelated donor search for bone marrow/stem cell transplant procedures – limited to $30,000

Exclusions

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

- Acupuncture (except for pain management)
- Alternative or complementary medicine
- Artificial and mechanical hearts
- Care provided by a member of your family
- Care received in an emergency room that is not emergency care, except as specified in the Subscriber Agreement
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services)
- Comfort and/or convenience items
- Compound drugs except as described in the Subscriber Agreement
- Cosmetic surgery and/or treatment that's primarily intended to improve your appearance
- Custodial care
- Dental, except as described in the Subscriber Agreement
- Educational services
- Experimental or investigative treatment
- Government coverage to the extent provided as benefits by any governmental unit, unless otherwise required by law or regulation
- Medicare benefits payable under Medicare Parts A, B and/or D, except as specified elsewhere in the Subscriber Agreement or as otherwise prohibited by federal law
- Nutritional and dietary supplements
- Over-the-counter drugs, devices or products
- Private duty nursing services unless specified as a Covered Service in the Subscriber Agreement
- Routine foot care, except as described in the Subscriber Agreement
- Sclerotherapy (a medical procedure used to eliminate varicose veins and spider veins)
- Services we determine aren't medically necessary
- Vision, except as described in the Subscriber Agreement
- Weight loss programs or treatment of obesity except as described in the Subscriber Agreement
- Workers' compensation

Medical loss ratio

For insurance entities, the term 'medical loss ratio' or (MLR) refers to the ratio of incurred claims to earned premium for a prior calendar year. The MLR is calculated for managed care (HMO) and PPO/Indemnity plans, one for state law purposes and the other as determined under federal law. For 2018, Anthem's Individual market segment MLR for state law purposes was 85.71% for HMO plans and 81.88% for PPO/Indemnity plans. For 2018, Anthem's MLR for federal law purposes was 89.5% for individual plans.

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

It's important we treat you fairly

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

GET HELP IN YOUR LANGUAGE

Curious to know what all this says? We would be too. Here's the English version:

If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (1-855-738-6644). (TTY/TDD: 711) Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number listed above.

Spanish

Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (1-855-738-6644). (TTY/TDD: 711)

Albanian

Nëse ju nevojitet ndihmë për ta kuptuar këtë dokument në një gjuhë tjetër, mund ta kërkoni pa kosto shtesë duke telefonuar në numrin e shërbimeve për anëtarët (1-855-738-6644). (TTY/TDD: 711)

Arabic

إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة.
إضافية من خلال الاتصال برقم خدمات الأعضاء (1-855-738-6644) (TTY/TDD: 711)

Chinese

如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(1-855-738-6644)請求免費協助。(TTY/TDD: 711)

French

Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 1-855-738-6644. (TTY/TDD: 711)

Greek

Αν χρειαστείτε βοήθεια για να κατανοήσετε το παρόν έγγραφο σε άλλη γλώσσα, μπορείτε να τη ζητήσετε χωρίς πρόσθετο κόστος καλώντας τον αριθμό του Τμήματος Υπηρεσιών Μέλους (1-855-738-6644). (TTY/TDD: 711)

Haitian

Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (1-855-738-6644). (TTY/TDD: 711)

Hindi

अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (1-855-738-6644) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

Italian

Se ha bisogno di assistenza per la comprensione del presente documento in un'altra lingua, può richiederla senza alcun costo aggiuntivo chiamando il numero dedicato ai Servizi per i membri (1-855-738-6644). (TTY/TDD: 711)

Korean

다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(1-855-738-6644)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Polish

Jeśli potrzebujesz pomocy w zrozumieniu niniejszego dokumentu w innym języku, możesz ją uzyskać bez ponoszenia dodatkowych kosztów, dzwoniąc do Działu Obsługi Klienta pod numer (1-855-738-6644). (TTY/TDD: 711)

Portuguese-Europe

Se necessitar de ajuda para compreender este documento noutro idioma, poderá solicitá-la gratuitamente ligando para o número dos Serviços para Membros (1-855-738-6644). (TTY/TDD: 711)

Russian

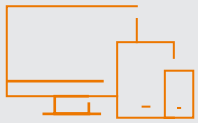
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (1-855-738-6644). (TTY/TDD: 711)

Tagalog

Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (1-855-738-6644). (TTY/TDD: 711)

Vietnamese

Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (1-855-738-6644). (TTY/TDD: 711)



WE'RE HERE TO HELP

Still have questions? Just ask.

To learn more, call Anthem or your licensed broker. You can also view and compare these Anthem health plans offered through Access Health CT online at anthem.com or **accesshealthct.com**.

05529CTMENABS 7/19