Looking for a new health plan?
We can help.

Anthem BlueCross BlueShield

2018 Plan Year: Connecticut

Individual and Family
Your health plan guide

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

Why Anthem?

Health plans don’t have to be complicated.

We understand that every individual and family is unique. That’s why we offer plan options for different health care needs and budgets. Our goal is not just to be there when you’re sick, but also to help you stay well – at every stage of life.

With Anthem Blue Cross and Blue Shield (Anthem), you can count on:

- A strong network with access to major hospital systems.
- One source for all your benefits, including dental and vision.
- Convenient online tools, including 24/7 access to doctors through LiveHealth Online.
- Coordinated care that connects your doctors and other health care providers.
- Resources to support your health care goals.

Anthem is right there with you.

It's time to expect more from health care plans.

- Local presence where you live and work
- A brand you can trust

You want the best value your health care dollars can buy. And in Connecticut, that's our goal — through our networks, our service and our experience.

* Based on Internal Data, 2017.

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

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The Basics

All our plan options have one major goal — to help you stay healthy and provide the quality coverage you need, when you need it.

Built-in benefits

Our plans include the essential health benefits (EHBs) required by the Affordable Care Act (ACA):

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services (going to the emergency room, also known as the ER) or urgent care center, when medically necessary
- Hospitalization and inpatient services (such as surgery)
- Laboratory and radiology services (includes blood work, screenings and X-rays)
- Mental health and substance use disorder services (includes counseling and psychotherapy)
- Pediatric dental and vision coverage for children up to age 19†

Take care of yourself with no-cost, in-network preventive care

With Anthem, you pay no copay, no coinsurance and no deductible for covered **in-network** preventive services. So you can stay on top of your health care and your finances!*

- Pregnancy, maternity and newborn care (care before, during and after pregnancy)
- Prescriptions
- Rehabilitative and habilitative services and devices (hospital beds, crutches, oxygen tanks)
- Visits to doctors in your plan for preventive care services* (wellness exams, shots, screenings) and chronic disease management

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

† If you choose a medical plan with out-of-network benefits, embedded dental benefits will also be available through out-of-network providers. If you choose a plan that only includes in-network benefits, the dental benefits will only be available through in-network providers. Remember, you save money when using in-network providers no matter which type of medical plan you choose.

Pharmacy

Getting the most out of your pharmacy benefits can help keep you healthy and save you money.

The Select Drug List has your medication needs covered

Your medical plan uses a formulary or drug list that includes hundreds of covered brand-name and generic drugs. Our individual and family plans use the Select Drug List, which offers drugs in every category and class that meet or exceed ACA requirements. Our drug list helps manage health care costs, while offering you the coverage you need.

To find out if your medication is covered, you can check out our Select Drug List at anthem.com/pharmacyinformation and click on the link, **Connecticut Select Drug List (Searchable)**.

Save with home delivery

We offer home delivery of your medicines right to your door — making it easy for you to get your medicine quickly and safely. People who use home delivery pharmacy are more likely to follow their medication treatment plan — meaning fewer doctor visits and hospital stays. And lower health care costs for you.

Access all of your pharmacy information at anthem.com

- See if your preferred pharmacy is in the plan's network. Visit anthem.com/findadoctor.
- Learn more about your pharmacy benefits, including why some drugs require prior authorization, by going to our FAQs at anthem.com/faqs/connecticut/pharmacy.

Members can access Anthem's online pharmacy tools – anytime, anywhere

When it comes to your health care, we look for ways to give members more value, convenience and control. The Anthem Anywhere app allows members to manage all their prescription benefits right from the palm of their hand:

- Compare retail prescription medication costs with Price a Medication
- Find an in-network pharmacy near you with Locate a Pharmacy
- Track your order status or quickly refill and renew your prescriptions with Order Status and Automatic Refills
- Get personalized reminders to ensure you're following your doctor's treatment plan using Pharmacy Care Alerts

Together with medical – better and easier than ever

- Better overall health
- A simplified experience
- Fewer hospital stays and reduced medical costs*
- Improved medication compliance
- Increased cost savings for prescriptions*

*Outcomes based on 2014 integrated analysis. Results don't represent a guarantee of outcomes, specific results and cost savings will vary.

How to choose a plan

Saving money on your medical bills is easy. See doctors in your plan. We'll show you how.

When you see a doctor or go to a hospital not in your health care plan, you'll be responsible for 100% of the cost, unless it's an emergency. But don't worry. We're here to help you choose a doctor in your plan to save money.

When Anthem sets up medical, dental and vision networks, we negotiate with doctors, hospitals and labs on the cost of services. For example, a doctor may normally charge $150 for an X-ray for a patient without medical benefits. We may sign an agreement with the doctor to discount all medical services given to Anthem members, including this X-ray.

Bottom line: Always check to see if your favorite doctor, hospital or other health care provider is in your plan, so you can get the benefit of the discounted or in-network rate. Out-of-state providers aren't covered unless it's an emergency.

Providers in your plan may include:

- Doctors, therapists, mental health providers and other health care professionals
- Hospitals and outpatient facilities
- Pharmacies
- ERs and urgent care centers
- Labs and radiology centers
- Durable medical equipment, like hospital beds, crutches, wheelchairs and oxygen tanks (retail and online stores)

Our Find a Doctor tool — it's quick and easy

Go to **anthem.com/findadoctor** and search using the plan/network (**Pathway X or Pathway X Enhanced**) you're considering.

You'll get a list of providers, including detailed information about them like location, gender, specialty, certifications, availability and much more.

For searches on the go, download our **Anthem Anywhere** mobile app to your mobile device.

Helpful hint:

Save emergency room visits for emergencies only

If you have a real emergency, head straight to the ER or call 911. Otherwise, save yourself money and time by visiting your primary care doctor or an urgent care center for minor medical issues.

Types of networks: PPO and HMO

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 doctor not in the plan for any other reason, you'll have to pay 100% out of pocket.

Travel coverage

Whether you're traveling for work or on vacation, going to the ER or urgent care is probably the last thing you want to worry about. The good news is you don't have to! With the Blue Cross and Blue Shield Association's BlueCard® program, you can access emergency care no matter where you are in the United States (U.S.).

Our **HMO** plans cover medically necessary emergency and urgent care in all 50 states at the in-network benefit level. Our **PPO** plans only cover medically necessary emergency and urgent care in all 50 states at the in-network benefit level. If you're enrolled in a **PPO** plan and get non-emergency care outside of Connecticut, you'll only be covered at the out-of-network benefit level.

Outside the U.S.

Our plans also include coverage for medically necessary emergency and urgent care when you visit participating BlueCard providers while traveling abroad.

Through the Blue Cross Global Core Service Center, members get:

- Claims support
- Doctor referrals
- Translation services
- 24/7 medical monitoring

Plus, the Blue Cross Global Core Service Center may also cover medical evacuation coordination and other services, depending on the member's benefits and home plan.

BlueCard national network access

BlueCard HMO:	Emergency visits and urgent care ONLY are covered at the in-network benefit level outside Connecticut.
BlueCard PPO:	Emergency visits and urgent care ONLY are covered at the in-network benefit level outside Connecticut. All other services are covered at the out-of-network benefit level.

If you go to a doctor not in your plan, you'll pay more out-of-network with PPO plans and you'll pay 100% out of pocket with HMO plans.

*UCLA Center for Health Policy Research website: In California, Primary Care Continuity Was Associated With Reduced Emergency Department Use and Fewer Hospitalizations (accessed January 2016): healthpolicy.ucla.edu.

What do you need?

Choosing the right health care plan can be challenging. To help you decide, consider the questions below. And remember, your Anthem licensed broker can provide answers and give advice.

What matters most to you?

Does the plan meet your coverage needs? How often do you see doctors and specialists? What prescription medications do you take regularly? Are you planning any procedures this year?

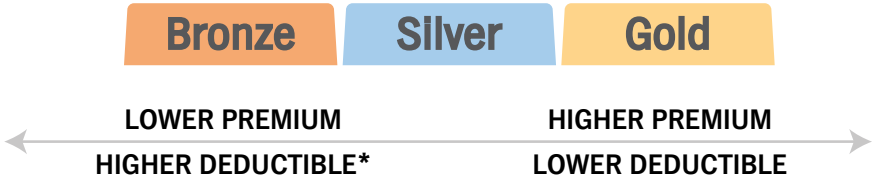
Do you have a certain doctor you like to see? If you answered yes, then you can use our Find a Doctor tool at **anthem.com/findadoctor** to check if your doctor is in the plan you're considering.

Do you need to know if your medication is covered? Check out our drug list at **anthem.com/pharmacyinformation** and choose the link, **Connecticut Select Drug List (Searchable)**.

Is a Catastrophic plan an option? If you're under age 30 or are 30 or older with an approved hardship exemption from Access Health CT (your state's Marketplace), you may qualify for a high-deductible, low monthly payment, Catastrophic plan. Catastrophic plans can help protect you from worst-case scenarios like serious accidents or illnesses.

Plan choices

Metal Levels



Health savings account (HSA)

If you like the idea of lowering your health care costs and your taxes, a health savings account (HSA) could be a good option for you.

- **What is an HSA?**
  It's a savings account you can open when you have a qualified high-deductible health plan (HDHP). You set up the HSA through a bank and fund it with your post tax dollars.
- **Why choose it?**
  It can help you pay for health care expenses, including prescriptions. Plus, you can claim your HSA contributions as tax deductions, earn interest on your money and roll over the year-end balance.
- **How can you learn more?**
  Check with your tax advisor to see if an HSA plan is right for you. For more information on HSAs, review our HSA flier included with this brochure.

* This does not apply to Silver cost-share reduction /subsidy plans. Silver cost-share reduction plans / subsidy plans are only available for Qualified Health Plans purchased through Access Health CT. Anthem Health Plans, Inc. is a Qualified Health Plan issuer that offers such plans through Access Health CT. Only your state exchange can determine eligibility for financial help.

How your plan might work

With most health care plans, you pay a monthly fee called a premium; then, you share some of the cost of covered services you receive with your health insurance company. **With Anthem, you choose the level of cost sharing that works for you.**

Here's an example: *Meet Jason**

To show you how your health plan might work, we'd like to introduce you to "Jason." The cost-share amounts used in this example may not apply to the plan you choose. This is just an example. Be sure to look at the actual benefits for each plan when you're deciding.

Jason's story

After injuring his knee in a soccer game, Jason chooses a doctor in our network, which saves him the most money. Jason pays a copay or coinsurance based on Anthem negotiated rates because he uses doctors in our network. **Below, see how Jason's benefits work, his treatment costs and why it's important to have health insurance:***

Jason's health plan has the following benefits:

- $2,000 deductible
- 30% coinsurance
- $5,000 out-of-pocket limit
- $35 copay for primary care doctor visits

Copay

On some plans, you pay a fixed-dollar amount or copay for certain services. For example, you may have a $35 copay for in-network primary care doctor visits.

Deductible

You pay this amount for covered medical services each calendar year, from January 1 through December 31. Your deductible starts over each calendar year.

Examples of covered services that apply to the deductible include lab work, X-rays, anesthesia and surgeon fees.

Let's take a closer look at Jason's doctor visit:

- *Doctor visit cost (without insurance):* $200
- *Anthem's negotiated rate:* $140
- *Anthem pays:* $105
- ▶ ***Jason paid:*** **$35**
  (This is his plan's copay for primary care doctor office visits.)

Here's what happens when Jason's doctor orders an approved magnetic resonance imaging (MRI) of the knee and recommends surgery:

MRI

- *MRI cost (without insurance):* $1,500
- *Anthem's negotiated rate:* $1,000
- ▶ ***Jason paid:*** **$1,000**
  (Jason's payment counts toward his plan's $2,000 deductible.)

Surgery

- *Hospital/surgery costs (without insurance):* $50,000
- *Anthem's negotiated rate:* $35,000
- ▶ ***Jason paid:*** **$1,000**
  (Jason's payment satisfies the remaining $1,000 deductible.)
- *Remaining cost of surgery:* $34,000

* While the characters in this example are not real, and the situation is hypothetical, the clinical aspects are accurate and realistic.

Coinsurance (your percentage of the cost)

Once you've met your deductible, Anthem starts paying a portion of your claims. Then, you and Anthem share responsibility for your health care bills. Your coinsurance is the percentage that you must pay for certain covered services. Having met his deductible, Jason begins to pay coinsurance on covered services that require it.

Let's check in to see Jason's final costs for surgery:

- *Coinsurance* (30% of $34,000): $10,200
- ***Jason paid:*** **$2,965**

(Jason's payment satisfies the remainder of his $5,000 out-of-pocket limit. Even though Jason's coinsurance is 30% or $10,200, he only has to pay a portion of that to meet his $5,000 out-of-pocket limit.)

Out-of-pocket limit

This is the most you pay during a calendar year for covered services. Your combined deductible, coinsurance and copay costs typically make up your out-of-pocket limit. Once you meet this limit, your health insurance covers 100% (of the maximum allowed amount) of covered services for the rest of the calendar year.

Jason has met his in-network out-of-pocket limit and the remaining surgery costs are paid by Anthem:

- *Anthem pays:* $31,035
- *Jason's out-of-pocket limit:* $5,000

Summary

Jason paid far less out of pocket because he had health care coverage and stayed in our network. If Jason had used a doctor outside our network, he would have paid more.

Keep in mind if your plan doesn't include coverage for out-of-network benefits, you'll pay the full cost for services from doctors not in your plan with the exception of medically necessary emergency and urgent care.

Let's check in to see Jason's final costs:

- *Total for the doctor visit, MRI and surgery (without health insurance):* $51,700
- *Total Anthem paid after discounts:* $31,140
- ***Total Jason paid:*** **$5,000**

($35 office visit + $2,000 deductible + $2,965 coinsurance = $5,000)

Call your Anthem licensed broker for more information.

You can also visit **anthem.com** or **accesshealthct.com** to view and compare different plans.

* While the characters in this example are not real, and the situation is hypothetical, the clinical aspects are accurate and realistic.

Overview of plans

Understanding insurance terms

In-network preventive care is covered at no additional cost to you!*

Insurance terms can be confusing. Here's a quick look at some commonly used health insurance terms.

Take a look at the following pages to see the individual and family medical plan choices offered by Anthem, including a sample of commonly used benefits and how they're covered under each plan. **Cost-share and benefit information shown is for *in-network* services only.**

For more information, contact your Anthem licensed broker. You can also view and compare plans on anthem.com.

Plan name	Plan name and contract code are found in 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.
Plan includes out-of-network coverage?	Indicates whether the plan includes coverage for out-of-network benefits. **In-network** refers to doctors who are part of the plan's network. **Out-of-network** refers to doctors who don't participate in the network.
Deductible	The **deductible** is a set amount that you pay out of pocket each year before your plan starts paying for covered services, except for in-network preventive services.* *For example:* If your deductible is $5,000, your plan won't pay anything until you've met your $5,000 deductible for covered health care services. Some plans may cover certain services, such as doctor office visits, before you meet the deductible. Our plans have embedded family deductibles, where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, before receiving plan benefits. No one family member pays more than the individual deductible. The medical plan charts display the individual deductible. Family deductibles are two (2) times the individual amount for most plans and three (3) times the individual amount for select Silver and Gold plans (see footnote at the end of the Medical plans charts). **Note:** You must meet your deductible every calendar year (January 1 through December 31), even if your effective date (the date your coverage begins) is later than January 1.
Out-of-pocket limit	The **out-of-pocket** limit is the most you pay during a policy period (each calendar year) before your health insurance or plan pays 100% of the maximum allowed amount. *For example:* If your out-of-pocket limit is $6,850, you will continue to pay your coinsurance and copays, if applicable, until you've met your $6,850 out-of-pocket limit. Once you have met your out-of-pocket limit, your plan pays 100% of the maximum allowed amount for covered services for the rest of that calendar year. This limit never includes your monthly payment (premium), additional charges from the doctor (balance billing), or services your plan doesn't cover. The amount includes deductible, copays, coinsurance and pharmacy costs. The medical plan charts display the individual out-of-pocket limit. Family out-of-pocket limits are two (2) times the individual amount.
Coinsurance	**Your percentage of the cost (Coinsurance)** is the amount you pay for covered health care services. It's a percentage of the cost of services after the deductible has been paid. *For example:* A health plan pays 80% of the maximum allowed amount for a service and you pay the remaining 20%. All medical plans have coinsurance, but the percentage may vary by health care service.
Copay	A **copay** is a fixed fee that you pay out of pocket for each visit to an in-network health care provider. *For example:* If your copay is $50, then you pay $50 when you see your in-network doctor — usually at the time you receive treatment. The amount of your copay may depend on the type of health care service you receive.

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

Medical plans

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 Access Health CT.

	Gold PPO Standard Pathway X (2J6U)	**Gold HMO Pathway X Enhanced (2VW0)**	**Silver PPO Standard Pathway X (2ER2)**
Network name	Pathway X	Pathway X Enhanced	Pathway X
Plan includes out-of-network coverage?	Yes	No	Yes
Individual deductible[1]	$1,250 / $3,000 (Family = 2x individual amt) In-network / Out-of-network	$2,500 (Family = 3x individual amt)	$3,700 / $7,400 (Family = 2x individual amt) In-network / Out-of-network
Individual out-of-pocket limit	$4,400 / $8,800 (Family = 2x individual amt) In-network / Out-of-network	$7,350 (Family = 2x individual amt)	$7,350 / $14,700 (Family = 2x individual amt) In-network / Out-of-network
Coinsurance (percentage may vary for some covered services)	0% / 30% In-network / Out-of-network	10%	0% / 40% In-network / Out-of-network
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$20 copay	$30 copay	$40 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	$40 copay	$50 copay	$50 copay
Office visit: LiveHealth Online web visit	$20 copay	$20 copay	$40 copay
Diagnostic tests[2] (Ex. X-ray, EKG)	Deductible, then $40 copay	Deductible, then 10% coinsurance	Deductible, then $40 copay
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	$65 copay up to a combined annual max of $375 for MRI and CAT scans; $400 for PET scans	Deductible, then 10% coinsurance	$75 copay up to a combined annual max of $375 for MRI and CAT scans; $400 for PET scans
Urgent care	$50 copay	Deductible, then $50 copay	$75 copay
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	$200 copay	Deductible, then $200 copay	Deductible, then $200 copay
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then $500 copay per day up to 2 days per admission	Deductible, then 10% coinsurance	Deductible, then $500 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 10% coinsurance	Deductible, then $500 copay
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2, 3: No deductible Tier 4: $50 Pharmacy deductible	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tier 1: No deductible Tiers 2, 3, 4: $250 Combined pharmacy deductible
Retail pharmacy tier 1[4]	$5	$5	$5
Retail pharmacy tier 2[4]	$25	$60	$35
Retail pharmacy tier 3[4]	$50	50% coinsurance (up to $250 per script)	$60
Retail pharmacy tier 4	20% coinsurance (up to $100 per script)	50% coinsurance (up to $750 per script)	20% coinsurance (up to $200 per script)
Physical and occupational therapy (limits apply)	$20 copay	Deductible, then $25 copay	$30 copay
Speech therapy (limits apply)	$20 copay	Deductible, then $25 copay	$30 copay

Please see Medical and Silver cost-share reduction plans footnotes on page 19.

Medical plans

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 Access Health CT.

	Silver Core PPO Pathway X (2ER9)	**Silver Low Deductible HMO Pathway X Enhanced (2VVL)**	**Silver High Deductible HMO Pathway X Enhanced (2VVT)**
Network name	Pathway X	Pathway X Enhanced	Pathway X Enhanced
Plan includes out-of-network coverage?	Yes	No	No
Individual deductible[1]	$5,300 / $15,900 (Family = 2x individual amt) In-network / Out-of-network	$3,950 (Family = 3x individual amt)	$6,150 (Family = 2x individual amt)
Individual out-of-pocket limit	$6,750 / $20,250 (Family = 2x individual amt) In-network / Out-of-network	$6,000 (Family = 2x individual amt)	$7,350 (Family = 2x individual amt)
Coinsurance (percentage may vary for some covered services)	25% / 50% In-network / Out-of-network	20%	25%
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$35 copay	$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance	$40 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coinsurance	Deductible, then $50 copay	Deductible, then 25% coinsurance
Office visit: LiveHealth Online web visit	$25 copay	$25 copay	$25 copay
Diagnostic tests[2] (Ex. X-ray, EKG)	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 25% coinsurance
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 25% coinsurance
Urgent care	Deductible, then $50 copay	Deductible, then $50 copay	Deductible, then $50 copay
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 25% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 25% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 25% 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: No deductible Tiers 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]	$5	$5	$5
Retail pharmacy tier 2[4]	$40	$60	$45
Retail pharmacy tier 3[4]	35% coinsurance (up to $250 per script)	50% coinsurance (up to $250 per script)	50% coinsurance (up to $250 per script)
Retail pharmacy tier 4	50% coinsurance (up to $750 per script)	50% coinsurance (up to $750 per script)	50% coinsurance (up to $750 per script)
Physical and occupational therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 25% coinsurance
Speech therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 20% coinsurance	Deductible, then 25% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 19.

Medical plans

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 Access Health CT.

	Bronze PPO Standard Pathway X for HSA (2J6P)	**Bronze PPO Standard Pathway X (2J6N)**	**Bronze HMO Pathway X Enhanced for HSA (1GUQ)**
Network name	Pathway X	Pathway X	Pathway X Enhanced
Plan includes out-of-network coverage?	Yes	Yes	No
Individual deductible[1]	$5,685 / $9,200 (Family = 2x individual amt) In-network / Out-of-network	$6,000 / $12,000 (Family = 2x individual amt) In-network / Out-of-network	$5,800 (Family = 2x individual amt)
Individual out-of-pocket limit	$6,550 / $12,900 (Family = 2x individual amt) In-network / Out-of-network	$7,350 / $14,700 (Family = 2x individual amt) In-network / Out-of-network	$6,650 (Family = 2x individual amt)
Coinsurance (percentage may vary for some covered services)	10% / 50% In-network / Out-of-network	0% / 50% In-network / Out-of-network	30%
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 10% coinsurance	$40 copay	Deductible, then 30% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 10% coinsurance	Deductible, then $50 copay	Deductible, then 30% coinsurance
Office visit: LiveHealth Online web visit	Deductible, then 10% coinsurance	$40 copay	Deductible, then 30% coinsurance
Diagnostic tests[2] (Ex. X-ray, EKG)	Deductible, then 10% coinsurance	Deductible, then $40 copay	Deductible, then 30% coinsurance
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	Deductible, then 10% coinsurance	Deductible, then $75 copay up to a combined annual max of $375 for MRI and CAT scans; $400 for PET scans	Deductible, then 30% coinsurance
Urgent care	Deductible, then 10% coinsurance	$75 copay	Deductible, then 30% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 10% coinsurance	Deductible, then $200 copay	Deductible, then 30% 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 30% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 10% coinsurance	Deductible, then $500 copay	Deductible, then 30% 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	Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]	10% coinsurance	$5	10% coinsurance
Retail pharmacy tier 2[4]	15% coinsurance	50% coinsurance	20% coinsurance
Retail pharmacy tier 3[4]	25% coinsurance	50% coinsurance	40% coinsurance (up to $250 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% coinsurance
Speech therapy (limits apply)	Deductible, then 10% coinsurance	Deductible, then $30 copay	Deductible, then 30% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 19.

Medical plans

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 Access Health CT.

	Bronze HMO Pathway X Enhanced (1GUR)	**Bronze High Deductible HMO Pathway X Enhanced (2VVC)**	**Catastrophic HMO Pathway X Enhanced (1GV7)◊**
Network name	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
Plan includes out-of-network coverage?	No	No	No
Individual deductible[1]	$6,250 (Family = 2x individual amt)	$6,500 (Family = 2x individual amt)	$7,350 (Family = 2x individual amt)
Individual out-of-pocket limit	$7,350 (Family = 2x individual amt)	$7,350 (Family = 2x individual amt)	$7,350 (Family = 2x individual amt)
Coinsurance (percentage may vary for some covered services)	30%	40%	0%
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$40 copay	Deductible, then 40% 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)	$50 copay	Deductible, then 40% coinsurance	Deductible, then 0% coinsurance
Office visit: LiveHealth Online web visit	$25 copay	Deductible, then 40% coinsurance	$25 copay
Diagnostic tests[2] (Ex. X-ray, EKG)	Deductible, then $40 copay	Deductible, then 40% coinsurance	Deductible, then 0% coinsurance
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	Deductible, then $75 copay up to a combined annual max of $375 for MRI and CAT scans; $400 for PET scans	Deductible, then 40% coinsurance	Deductible, then 0% coinsurance
Urgent care	Deductible, then $75 copay	Deductible, then 40% coinsurance	Deductible, then 0% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 0% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2, 3, 4: Medical deductible applies	Tiers 1, 2, 3, 4: Medical deductible applies	Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]	10% coinsurance	30% coinsurance	0% coinsurance
Retail pharmacy tier 2[4]	20% coinsurance	40% coinsurance	0% coinsurance
Retail pharmacy tier 3[4]	40% coinsurance (up to $250 per script)	50% coinsurance (up to $250 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)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then 0% coinsurance
Speech therapy (limits apply)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then 0% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 19.

Silver cost-share reduction (CSR) plans

Cost share may vary based on where you receive care. 73% Silver CSR, 87% Silver CSR and 94% Silver CSR plans are available if you qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on Access Health CT. Have questions? Call your Anthem licensed broker.

	Silver PPO Standard Pathway X (2ER2)	Silver PPO Standard Pathway X 73% CSR (2ER3)	Silver PPO Standard Pathway X 87% CSR (2ER4)	Silver PPO Standard Pathway X 94% CSR (2ER5)
Network name	Pathway X	Pathway X	Pathway X	Pathway X
Plan includes out-of-network coverage?	Yes	Yes	Yes	Yes
Individual deductible[1]	$3,700 / $7,400 (Family = 2x individual amt) In-network / Out-of-network	$3,350 / $7,400 (Family = 2x individual amt) In-network / Out-of-network	$600 / $7,400 (Family = 2x individual amt) In-network / Out-of-network	$0 / $7,400 (Family = 2x individual amt) In-network / Out-of-network
Individual out-of-pocket limit	$7,350 / $14,700 (Family = 2x individual amt) In-network / Out-of-network	$5,850 / $14,700 (Family = 2x individual amt) In-network / Out-of-network	$2,000 / $14,700 (Family = 2x individual amt) In-network / Out-of-network	$750 / $14,700 (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)	$50 copay	$50 copay	$35 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 up to a combined annual max of $375 for MRI and CAT scans; $400 for PET scans	$75 copay up to a combined annual max of $375 for MRI and CAT scans; $400 for PET scans	$60 copay up to a combined annual max of $360 for MRI and CAT scans; $400 for PET scans	$50 copay 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 waived if admitted into the hospital from the emergency room.)	Deductible, then $200 copay	Deductible, then $200 copay	Deductible, then $75 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]	$5	$5	$5	$5
Retail pharmacy tier 2[4]	$35	$35	$20	$10
Retail pharmacy tier 3[4]	$60	$60	$35	$30
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
Speech therapy (limits apply)	$30 copay	$30 copay	$20 copay	$20 copay

Please see Medical and Silver cost-share reduction plans footnotes on page 19.

Silver cost-share reduction (CSR) plans

Cost share may vary based on where you receive care. 73% Silver CSR, 87% Silver CSR and 94% Silver CSR plans are available if you qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on Access Health CT. Have questions? Call your Anthem licensed broker.

	Silver Core PPO Pathway X (2ER9)	Silver Core PPO Pathway X 73% CSR (2ERA)	Silver Core PPO Pathway X 87% CSR (2ERB)	Silver Core PPO Pathway X 94% CSR (2ERC)
Network name	Pathway X	Pathway X	Pathway X	Pathway X
Plan includes out-of-network coverage?	Yes	Yes	Yes	Yes
Individual deductible[1]	$5,300 / $15,900 (Family = 2x individual amt) In-network / Out-of-network	$4,000 / $15,900 (Family = 2x individual amt) In-network / Out-of-network	$900 / $15,900 (Family = 2x individual amt) In-network / Out-of-network	$250 / $15,900 (Family = 2x individual amt) In-network / Out-of-network
Individual out-of-pocket limit	$6,750 / $20,250 (Family = 2x individual amt) In-network / Out-of-network	$5,350 / $20,250 (Family = 2x individual amt) In-network / Out-of-network	$1,750 / $20,250 (Family = 2x individual amt) In-network / Out-of-network	$750 / $20,250 (Family = 2x individual amt) In-network / Out-of-network
Coinsurance (percentage may vary for some covered services)	25% / 50% In-network / Out-of-network	25% / 50% In-network / Out-of-network	25% / 50% In-network / Out-of-network	25% / 50% In-network / Out-of-network
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$35 copay	$35 copay	$30 copay	$25 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Office visit: LiveHealth Online web visit	$25 copay	$25 copay	$20 copay	$15 copay
Diagnostic tests[2] (Ex. X-ray, EKG)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Urgent care	Deductible, then $50 copay	Deductible, then $50 copay	Deductible, then $50 copay	Deductible, then $50 copay
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% 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: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]	$5	$5	$5	$5
Retail pharmacy tier 2[4]	$40	$40	$40	$25
Retail pharmacy tier 3[4]	35% coinsurance (up to $250 per script)	35% coinsurance (up to $250 per script)	35% coinsurance (up to $250 per script)	35% coinsurance (up to $250 per script)
Retail pharmacy tier 4	50% coinsurance (up to $750 per script)	50% coinsurance (up to $750 per script)	50% coinsurance (up to $750 per script)	50% coinsurance (up to $750 per script)
Physical and occupational therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Speech therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 19.

Silver cost-share reduction (CSR) plans

Cost share may vary based on where you receive care. 73% Silver CSR, 87% Silver CSR and 94% Silver CSR plans are available if you qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on Access Health CT. Have questions? Call your Anthem licensed broker.

	Silver Low Deductible HMO Pathway X Enhanced (2VVL)	**Silver Low Deductible HMO Pathway X Enhanced 73% CSR (2VVP)**	**Silver Low Deductible HMO Pathway X Enhanced 87% CSR (2VVQ)**	**Silver Low Deductible HMO Pathway X Enhanced 94% CSR (2VVR)**
Network name	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
Plan includes out-of-network coverage?	No	No	No	No
Individual deductible[1]	$3,950 (Family = 3x individual amt)	$2,800 (Family = 2x individual amt)	$700 (Family = 2x individual amt)	$300 (Family = 2x individual amt)
Individual out-of-pocket limit	$6,000 (Family = 2x individual amt)	$5,100 (Family = 2x individual amt)	$1,800 (Family = 2x individual amt)	$600 (Family = 2x individual amt)
Coinsurance (percentage may vary for some covered services)	20%	20%	20%	20%
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance	$30 copay per visit for the first 3 visits, then deductible and 0% coinsurance	$20 copay per visit for the first 3 visits, then deductible and 0% coinsurance	$15 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 $50 copay	Deductible, then $50 copay	Deductible, then $30 copay	Deductible, then $30 copay
Office visit: LiveHealth Online web visit	$25 copay	$20 copay	$15 copay	$10 copay
Diagnostic tests[2] (Ex. X-ray, EKG)	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Urgent care	Deductible, then $50 copay	Deductible, then $50 copay	Deductible, then $50 copay	Deductible, then $25 copay
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% 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: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]	$5	$5	$5	$5
Retail pharmacy tier 2[4]	$60	$60	$40	$35
Retail pharmacy tier 3[4]	50% coinsurance (up to $250 per script)	40% coinsurance (up to $250 per script)	0% coinsurance	0% coinsurance
Retail pharmacy tier 4	50% coinsurance (up to $750 per script)	40% coinsurance (up to $750 per script)	0% coinsurance	0% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance
Speech therapy (limits apply)	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 19.

Silver cost-share reduction (CSR) plans

Cost share may vary based on where you receive care. 73% Silver CSR, 87% Silver CSR and 94% Silver CSR plans are available if you qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on Access Health CT. Have questions? Call your Anthem licensed broker.

	Silver High Deductible HMO Pathway X Enhanced (2VVT)	Silver High Deductible HMO Pathway X Enhanced 73% CSR (2VVW)	Silver High Deductible HMO Pathway X Enhanced 87% CSR (2VVX)	Silver High Deductible HMO Pathway X Enhanced 94% CSR (2VVY)
Network name	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced	Pathway X Enhanced
Plan includes out-of-network coverage?	No	No	No	No
Individual deductible[1]	$6,150 (Family = 2x individual amt)	$3,300 (Family = 2x individual amt)	$950 (Family = 2x individual amt)	$400 (Family = 2x individual amt)
Individual out-of-pocket limit	$7,350 (Family = 2x individual amt)	$5,850 (Family = 2x individual amt)	$2,000 (Family = 2x individual amt)	$700 (Family = 2x individual amt)
Coinsurance (percentage may vary for some covered services)	25%	25%	25%	25%
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$40 copay	$10 copay	$5 copay	$5 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Office visit: LiveHealth Online web visit	$25 copay	$5 copay	$5 copay	$5 copay
Diagnostic tests[2] (Ex. X-ray, EKG)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Urgent care	Deductible, then $50 copay	Deductible, then $50 copay	Deductible, then $50 copay	Deductible, then $50 copay
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% 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: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]	$5	$5	$5	$5
Retail pharmacy tier 2[4]	$45	$35	$20	$20
Retail pharmacy tier 3[4]	50% coinsurance (up to $250 per script)	40% coinsurance (up to $250 per script)	30% coinsurance (up to $250 per script)	30% coinsurance (up to $250 per script)
Retail pharmacy tier 4	50% coinsurance (up to $750 per script)	50% coinsurance (up to $750 per script)	40% coinsurance (up to $750 per script)	40% coinsurance (up to $750 per script)
Physical and occupational therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Speech therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance

Please see Medical and Silver cost-share reduction plans footnotes on page 19.

Medical and Silver cost-share 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 and three (3) times the individual amount for the following plans: Silver Low Deductible HMO Pathway X Enhanced (2VVL) and Gold HMO Pathway X Enhanced (2VW0).
2 Cost shares listed for **Diagnostic tests** and **Advanced diagnostic tests** reflect services received in an outpatient setting.
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.

Getting the dental plans you need

Standalone coverage from Anthem can help you get the dental care you need for your total health. Many of our dental plans cover you 100% for exams, cleanings and x-rays.

Anthem dental plans

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

- Anthem Dental Family Value
- Anthem Dental Family
- Anthem Dental Family Enhanced

Anthem has one of the largest dental preferred provider organization (PPO) networks in the country.* Plus, we work with in-network dentists to get deep discounts for you. By seeing a dentist in the plan, you can save an average of 25% to 32% on covered dental services.† To see more of what we cover, take a look at the **Dental plans** on the next page.

Anthem Dental Family Value, Anthem Dental Family and Anthem Dental Family Enhanced plans

Our plans offer these advantages:

- You will not be charged premiums for more than three children.
- For children, families will not be charged more than twice the out-of-pocket limit, regardless of how many children are in the family.
- The Anthem Dental Family Value, Anthem Dental Family and Anthem Dental Family Enhanced plans cover everyone.

Tools that put a smile on your face

We offer some great online tools to help you better understand your dental health. Once you're a member, log in to anthem.com to access:

Ask a Hygienist

Email questions to licensed dental professionals and get quick, private personalized advice at no extra cost.

Dental Cost Estimator

Help estimate your costs for certain dental procedures and services in the ZIP code where you get care.

Dental Health Assessment

Get feedback based on your unique responses to a few questions to help you keep a healthy smile.

The medical + dental advantage

Coordinating medical and dental plans can result in better care – delivered sooner and at a lower cost. Plus, you enjoy the convenience of having only one ID card and one bill when you purchase all your coverage from Anthem.

* Network data from Strenuus, August 2016.
† Internal data, 2015.

Dental plans

Cost share shows what a member pays	Anthem Dental Family Value		Anthem Dental Family		Anthem Dental Family Enhanced	
	(Dependents age 18 and younger)	(Adults age 19+)	(Dependents age 18 and younger)	(Adults age 19+)	(Dependents age 18 and younger)	(Adults age 19+)
	In-network / Out-of-network	**In-network / Out-of-network**	**In-network / Out-of-network**	**In-network / Out-of-network**	**In-network / Out-of-network**	**In-network / Out-of-network**
Dental network	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime
Deductible (per person, all services)	$50	$50	$50	$50	$60[1]	$60[1]
Annual Maximum (per person)	None	$1,000	None	$1,000	None	$2,000
Annual out-of-pocket limit	$350[2] / None	None	$350[2] / None	None	$350[2] / None	None
Diagnostic and preventive	No waiting period	No waiting period	No waiting period	No waiting period	No waiting period	No waiting period
Cleaning, exams and x-rays	0% / 0% coinsurance	0% / 30% coinsurance	0% / 0% coinsurance	0% / 30% coinsurance	0% / 20% coinsurance	0% / 20% coinsurance
Basic services	No waiting period	6-month waiting period	No waiting period	6-month waiting period	No waiting period	6-month waiting period
Fillings	40% / 40% coinsurance	40% / 50% coinsurance	40% / 40% coinsurance	40% / 50% coinsurance	20% / 40% coinsurance	20% / 40% coinsurance
Brush biopsy	Not covered	Covered	Not covered	Covered	Not covered	Covered
Complex and major services	No waiting period	Not covered	No waiting period	12-month waiting period	No waiting period	12-month waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	50% / 50% coinsurance	40% / 50% coinsurance	40% / 50% coinsurance
Prosthetics (crowns, dentures, bridges)	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	50% / 50% coinsurance	40% / 50% coinsurance	40% / 50% coinsurance
Medically necessary orthodontia	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	Not covered
Cosmetic orthodontia	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
International emergency dental program	Included	Included	Included	Included	Included	Included

Note: This is only a brief description of some plan benefits. Please refer to the Subscriber Agreement for more complete details including benefits, limitations and exclusions.

Please see Dental plans footnotes on page 22.

Dental plans footnotes

1 With our Dental Family Enhanced Plans, the deductible is waived for **Diagnostic** and **Preventive** services received in our network.

2 Per child, up to $700 per family.

Our plans' built-in extras

At Anthem, we want to be more than your health benefits plan — we want to help you meet your day-to-day health and wellness goals. That's why we offer a variety of programs, discounts and tools to support you being your healthy best.

Health and wellness resources

Whether you're looking for one-on-one coaching or pregnancy support, we're here to give you the guidance you need, when you need it — at no extra cost. **Here's how:**

24/7 Nurseline — is staffed with registered nurses who are just a phone call away at any time. Nurses can answer questions about a medical concern or help you choose the right level of care. Plus, you can call the same phone line and listen to hundreds of health topics in the AudioHealth Library.

Care Support — gives you the extra care and support you need for your ongoing or complex health issues. A case manager may call you to see how we can help keep your condition in check and give you information as well as emotional support services.

And don't forget about those regular checkups! Your yearly exams, flu shots and other preventive care services are covered 100% when you visit in-network providers. These services can give you extra support in managing your health or a specific health condition.

MyHealth Advantage — helps keep you healthier. We review your incoming health claims and remind you if you've missed a routine test or checkup. We also check the medications you take in the event your doctor needs to be alerted of possible drug interactions or if you could save money. If we find something that can help you, we'll mail you a confidential MyHealth Note. Or, download the Anthem Anywhere app and choose to receive your personalized, secure health messages on-the-go through the Mobile Inbox.

SpecialOffers@Anthem℠

SpecialOffers@Anthem℠ (SpecialOffers) is our member discount program for health- and wellness-related products and services.

Through the program, members can enjoy discounts on:

- Vitamins
- Health and beauty products
- Massage therapy
- LASIK eye surgery
- Eyeglass frames and contact lenses
- Hearing aids and services
- Jenny Craig® and Weight Watchers® weight-loss programs*
- Smoking cessation programs

* WEIGHT WATCHERS and PointsPlus are the registered trademarks of Weight Watchers International, Inc. Trademarks used under license by WeightWatchers.com, Inc.

Enhanced Personal Health Care

Enhanced Personal Health Care (EPHC) is a kind of doctor-patient relationship created just for Anthem members!

We put members in a unique circle of care, making them the central focus of a team approach to their overall health.

Enhanced Personal Health Care — a program that:

- Helps to improve your patient experience with better access to a primary care doctor who cares for the "whole person" and becomes your health care champion and helps you navigate the health care system.
- Gives doctors added support with the right tools and strategies to help strengthen your doctor-patient relationship, so doctors can spend more time with you and coordinate your care with other doctors.

To find out if your primary care doctor is in the EPHC program, go to **anthem.com/findadoctor**. If your doctor is in the program, you'll see Quality Snapshot within the doctor's listing and the EPHC designation (a heart symbol with a plus sign) under Other Certifications.

Together, you and your doctor work to make the best choices for your health care.

Online Tools

From our website and mobile app to cost and quality comparison tools, we want to make sure you have the information you need to make informed health care decisions for you and your family.

Our secure website:

- Get a breakdown of what is and isn't covered by your plan through a benefit summary.
- See your recent claims and coverage details.
- Pay your premium online.
- Estimate your costs before having certain procedures.
- Manage your prescription benefits and search the drug list that applies to your benefit plan.

Our Anthem Anywhere app:

- Find a doctor, hospital or pharmacy
- Get a virtual ID card
- Compare doctor costs and quality
- Manage prescription benefits
- View claims

Cost and quality information with Estimate Your Cost

With our Estimate Your Cost tool, you can save time and money by comparing the cost of common procedures at health care facilities in your area. You'll also get to see the quality and safety ratings for those facilities.

LiveHealth® ONLINE

Now you can have a private video visit with a doctor or therapist on your smartphone, tablet or computer. LiveHealth Online* is an easy and convenient way to get the care you need from the comfort and privacy of home.

All you have to do is sign up at **livehealthonline.com** to use it!

- Get medical advice, diagnoses, proper treatment and even prescriptions, 24/7 in about 10 minutes or less
- Quickly address common health problems, like allergies, colds, rashes, fever and more

Now, you can talk to a licensed therapist or psychologist at home. If you're feeling stressed, worried or having a tough time, we're here to help.

- See a therapist in four days or less†
- Choose a time that's convenient for you - seven days a week from 7 a.m. to 11 p.m.

Doctors typically charge $49 or less per visit and therapists usually cost the same as what you'd pay for an office therapy visit, depending on your medical plan.‡

Always have your benefit details in hand. Register at anthem.com.

Sign up at **anthem.com** to access your benefits online. And don't forget to download the **Anthem Anywhere** mobile app, so you can manage your benefits at home or on the go.

* LiveHealth Online is the trade name of the Health Management Corporation.
† Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications.
‡ Depending on your coverage, the cost may be similar to what you would pay for an office visit, considering your benefits, copay or coinsurance.

Ready to enroll? Let's get started.

If you're ready to take the next step and enroll, we're here to help you every step of the way.

To get started, you'll need to have the following information handy:

1. **Employer and income details** (for example, pay stubs and W-2 forms) for every member of your household who needs coverage
2. **Policy numbers and insurer names and name of every job-based health insurance plan** for any current health insurance plans covering members of your household or for which you or someone in your household is eligible
3. **Find and designate an in-network PCP** to coordinate care and act as a primary resource for any health concerns

Then, you can:

4. **Call Anthem or your licensed broker** to enroll or learn more about our health care plans; or
5. **Find our plans** on Access Health CT at **accesshealthct.com**.

Generally, plans can be purchased once a year through an open enrollment period. This year, the open enrollment period runs from November 1, 2017 through December 22, 2017. Be sure to enroll by December 22, 2017, to start coverage effective January 1, 2018.

There are special qualifying events that may allow you to change your health coverage outside of the open enrollment period. Check with Anthem or your licensed broker to see if you qualify or if you have other questions about open enrollment.

Why do I need to designate a PCP?

Whether you go to a doctor rarely or often, it's important to have a designated PCP. As your main doctor, a PCP has a view of your overall health and will be your first point of contact for any health concerns or questions.

Simplified payments

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

- 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 Anthem Anywhere 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 expiration date stays up to date.

We want you to be satisfied

After you enroll in one of our plans, you'll have access to a *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.

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 access a ***Summary of Benefits and Coverage (SBC)***, please visit **sbc.anthem.com** and select **Member**.

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
- Deductibles, copays, coinsurance and out-of-pocket limits

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

Still have questions?

Please reach out to Anthem or your licensed broker. If you're stuck and unsure about next steps, we're here to listen and offer advice. We know there's a great plan out there just for you - let us help you find it!

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 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.

Depending on the event which triggered 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 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.

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. Here are some types of medical treatments that might call for a pre-service review:

- An inpatient 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
- 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, 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.

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 as an authorized service.

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 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. 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
- Skilled nursing facility – 90 visits per member per year
- 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
- Benefits covered by Medicare or a governmental program
- 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
- 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
- Non-chemical addictions such as gambling, spending, religious
- Nutritional and dietary supplements
- Over-the-counter drugs, devices or products
- Penile prostheses or implants and vascular or artificial reconstruction, prescription drugs, and all other procedures and equipment for the treatment of impotency, and all related diagnostic testing
- Private duty nursing
- Routine foot care
- 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 mandated
- 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 2016, Anthem's Individual market segment MLR for state law purposes was 94.9% for HMO plans and 103.6% for PPO/Indemnity plans. For 2016, Anthem's MLR for federal law purposes was 85.2% for individual plans.

SpecialOffers is a service mark of Anthem Insurance Companies, Inc. Vendors and offers are subject to change without notice. Anthem does not endorse and is not responsible for the products, services or information provided by the SpecialOffers vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members. All other marks are the property of their respective owners. All of the offers in the SpecialOffers program are continually being evaluated and expanded so the offerings may change. Any additions or changes will be communicated on our website, anthem.com. These arrangements have been made to add value for our members. Value-added products and services are not covered by your health plan benefit. Available discount percentages may change or be discontinued from time to time without notice. Discount is applicable to the items referenced.

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 extra 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 phone number on the back of your ID card.

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)

Anthem BlueCross BlueShield

Get help today!

To learn more, call Anthem or your licensed broker. You can also view 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.

Your HSA:

Enjoy the advantages of opening a Health Savings Account (HSA) from BenefitWallet®

A Health Savings Account can help you pay for health care expenses including prescriptions. Plus, you can claim your HSA contributions as tax deductions, earn interest on your money and roll over the year-end balance.

To realize your plan's full power, consider selecting a qualified high-deductible health plan with an HSA. Our partner, BenefitWallet, administers our HSA solution with The Bank of New York Mellon as the custodian. Setting up your account with BenefitWallet is easy and it comes with built-in advantages and conveniences like:

- A single Customer Service contact for the health plan and your HSA
- A single online health site to access your plan benefit information and account details
- Several payment and deposit options, including debit cards, checks and automatic fund transfers
- Ability to save your receipt images online
- Competitive interest rates and investment opportunities for the funds in your account
- iPhone®, iPad® and Android™ apps for access anywhere
- Health Topics encyclopedia of more than 1,500 ailments
- Medication Advisor for drugs and pharmacy identifier
- Treatment Cost Advisor for common medical conditions
- FDIC-insured checking account with the custodian, The Bank of New York Mellon (BNY Mellon)

Note: You also have the option of using a different financial institution to set up your Health Savings Account.

Set up is easy

Simply make the selection on your application form and we'll send you welcome materials to get you started. Account registration instructions are included. It's that simple.

Anthem BlueCross BlueShield

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A closer look at your BenefitWallet HSA

BenefitWallet Welcome Materials

If you make the selection on your application form, your HSA will automatically be set up - no set-up fee required. You'll soon receive HSA welcome materials with all of the instructions for opening and using your account. A separate application for your account is only required if you choose an HSA administrator other than BenefitWallet.

Interest and investments

You'll earn interest on your HSA funds and have the chance to invest your funds as long as you keep a minimum $1,000 HSA balance. Investment options include a number of mutual fund families. Once you're ready to invest, log in to your account and select "Investments" from the Quick Links menu or contact the BenefitWallet Service Center at **866-686-4798,** Monday through Friday, from 8 a.m. to 11 p.m. ET.

Debit cards, checkbooks and online bill pay

Use your VISA debit card, your HSA checkbook or online bill pay (provided by BenefitWallet) to pay your doctor or pharmacy directly for eligible medical expenses — or to reimburse yourself for qualified medical expenses paid out of pocket.

Deposits to your account

You can make your deposits online or with a mobile app. You can also send a check and deposit slip to the address printed on your deposit slip. Deposit slips can be found at the back of the checkbook, online through the Help Center or through the BenefitWallet Service Center. In addition, you can set up an electronic funds transfer between your bank and BenefitWallet for one-time or recurring account contributions.

Account activity statement

Regularly, you'll receive an electronic statement from BenefitWallet that shows all your account activity. Your monthly statement is free if you open your account electronically. You can receive a paper statement for an additional fee of $1.25 per month. Visit anthem.com or call your dedicated Customer Service line to learn how to elect this option. You'll also receive *IRS 1099* and *IRS 5498* forms from BNY Mellon near tax time to help with tax preparation.

BenefitWallet HSA fee and rate schedule

A *Deposit Agreement* and *Disclosure Statement,* along with a *Rate and Fee Sheet* will be made available to you by BenefitWallet. Please refer to those documents for the complete terms and conditions related to your account.

As appealing as these options may sound, you should still talk to your tax advisor when trying to maximize financial benefits for your personal situation.

Banking fees	
Monthly account fee	$2.95
First two debit cards, debit card transactions, first checkbook, check writing, online bill pay, electronic transfers	no charge
ATM transactions	$2
Card replacement Duplicate check	$5
Check reorder	$10
Nonsufficient funds	$25
Stop-check service	$25
Periodic paper statement	$1.25

This is what the IRS requires if you want to open a Health Savings Account:

- **You must be covered by an HSA-compatible, high-deductible health plan.**
- **You must be a U.S. resident, and not a resident of Puerto Rico or American Samoa.**
- **You cannot be covered by any other medical plan that is not an HSA-compatible, high-deductible health plan.**
- **You cannot be enrolled in Medicare.**
- **You cannot be claimed as a dependent on another individual's tax return.**
- **If you are a veteran, you may not have received veteran's benefits within the last three months.**
- **You cannot be active military.**
- **Your spouse cannot be enrolled in an FSA plan.**