Connecticut

Anthem

2021 Plan Year Benefit Charts

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

Open Enrollment Period runs
November 1, 2020 - December 15, 2020

HEALTH COVERAGE CREATED WITH YOU IN MIND

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06315CTMENABS 10/20

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. For our BlueCare Prime network, referrals to specialists are required.

Plan name	Bronze HMO Pathway Enhanced Tiered (5L2W)[Δ]	Bronze PPO Standard Pathway for HSA (5L33)	Bronze PPO Standard Pathway (5L32)	Bronze HMO BlueCare Prime (5L3Z)[†]	Silver PPO Standard Pathway (5L3L)	Gold HMO Pathway Enhanced Tiered (5L3A)[Δ]	Gold PPO Standard Pathway (5L3G)
Network name	Pathway Enhanced Tiered	Pathway	Pathway	BlueCare Prime[†]	Pathway	Pathway Enhanced Tiered	Pathway
Plan includes out-of-network coverage?	No	Yes	Yes	No	Yes	No	Yes
Individual deductible[1]	Tier 1: $5,900 (Family = 2x individual amt) Tier 2: $7,900 (Family = 2x individual amt)	$6,350 / $12,700 (Family = 2x individual amt) In-network / Out-of-network	$6,550 / $13,100 (Family = 2x individual amt) In-network / Out-of-network	$7,000 (Family = 2x individual amt)	$4,300 / $8,600 (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)	$1,300 / $3,000 (Family = 2x individual amt) In-network / Out-of-network
Individual out-of-pocket limit	$8,550 (Family = 2x individual amt)	$6,900 / $13,800 (Family = 2x individual amt) In-network / Out-of-network	$8,550 / $17,100 (Family = 2x individual amt) In-network / Out-of-network	$8,550 (Family = 2x individual amt)	$8,150 / $16,300 (Family = 2x individual amt) In-network / Out-of-network	$8,550 (Family = 2x individual amt)	$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%	20% / 50% In-network / Out-of-network	0% / 50% In-network / Out-of-network	50%	0% / 40% In-network / Out-of-network	Tier 1: 10% Tier 2: 30%	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	Deductible, then 20% coinsurance	$50 copay	$30 copay	$40 copay	Tier 1: $30 copay Tier 2: Deductible, then 30% coinsurance	$20 copay
Office and online 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	Deductible, then 20% coinsurance	Deductible, then $70 copay	Deductible, then $70 copay	$60 copay	Tier 1: Deductible, then $60 copay Tier 2: Deductible, then 30% coinsurance	$40 copay
Online primary care doctor visit: LiveHealth Online	$20 copay	Deductible, then 20% coinsurance	$50 copay	$10 copay	$40 copay	$10 copay	$20 copay
Diagnostic tests[2] (Ex. X-ray, EKG)	Tier 1: Deductible, then $40 copay Tier 2: Deductible, then 50% coinsurance	Deductible, then 20% coinsurance	Deductible, then $40 copay	Deductible, then 50% coinsurance	Deductible, then $40 copay	Tier 1: Deductible, then 10% coinsurance Tier 2: Deductible, then 30% coinsurance	Deductible, then $40 copay
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	Tier 1: Deductible, then $75 copay Tier 2: Deductible, then 50% coinsurance	Deductible, then 20% coinsurance	Deductible, then $75 copay	Deductible, then 50% coinsurance	$75 copay	Tier 1: Deductible, then 10% coinsurance Tier 2: Deductible, then 30% coinsurance	$65 copay
Urgent care (Other office services may be subject to deductible and plan coinsurance)	$75 copay	Deductible, then 20% coinsurance	$75 copay	$75 copay	$75 copay	Deductible, then 10% coinsurance	$50 copay
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 50% coinsurance	Deductible, then 20% coinsurance	Deductible, then $450 copay	Deductible, then 50% coinsurance	Deductible, then $450 copay	Deductible, then 30% coinsurance	$400 copay
Hospital: inpatient admission (includes maternity, mental health / substance use)	Tier 1: Deductible, then $650 copay per day up to 2 days per admission Tier 2: Deductible, then 50% coinsurance	Deductible, then 20% coinsurance	Deductible, then $500 copay per day up to 2 days per admission	Deductible, then 50% coinsurance	Deductible, then $500 copay per day up to 4 days per admission	Tier 1: Deductible, then 10% coinsurance Tier 2: Deductible, then 30% coinsurance	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 20% coinsurance	Deductible, then $500 copay	Deductible, then 50% coinsurance	Deductible, then $500 copay	Tier 1: Deductible, then 10% coinsurance Tier 2: Deductible, then 30% coinsurance	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	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	Tier 1: No deductible Tiers 2, 3, 4: $250 Combined pharmacy deductible	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2, 3: No deductible Tier 4: $50 Pharmacy deductible
Retail pharmacy tier 1[4]	$25 copay	20% coinsurance	$20 copay	$15 copay	$10 copay	$5 copay	$5 copay
Retail pharmacy tier 2[4]	50% coinsurance	25% coinsurance	50% coinsurance	$50 copay	$45 copay	$60 copay	$35 copay
Retail pharmacy tier 3[4]	50% coinsurance (up to $500 per script)	30% coinsurance	50% coinsurance	50% coinsurance (up to $500 per script)	$70 copay	50% coinsurance (up to $500 per script)	$60 copay
Retail pharmacy tier 4	50% coinsurance (up to $750 per script)	30% coinsurance (up to $500 per script)	50% coinsurance (up to $500 per script)	50% coinsurance (up to $750 per script)	20% coinsurance (up to $200 per script)	50% coinsurance (up to $750 per script)	20% coinsurance (up to $100 per script)
Physical and occupational therapy (limits apply)	Deductible, then $30 copay	Deductible, then 20% coinsurance	Deductible, then $30 copay	Deductible, then $30 copay	$30 copay	$30 copay	$20 copay

Individual and Family Benefit Charts for Connecticut anthem.com |

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. For our BlueCare Prime network, referrals to specialists are required.

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.

Plan name	Gold HMO BlueCare Prime (5L3U)†	CatastrophicHMOPathwayEnhanced (5L38)◊
Network name	BlueCare Prime†	Pathway Enhanced
Plan includes out-of-network coverage?	No	No
Individual deductible[1]	$2,500 (Family = 2x individual amt)	$8,550 (Family = 2x individual amt)
Individual out-of-pocket limit	$8,550 (Family = 2x individual amt)	$8,550 (Family = 2x individual amt)
Coinsurance (percentage may vary for some covered services)	20%	0%
Office visit: primary care physician (PCP) (Other office services may be subject to deductible and plan coinsurance)	$30 copay	$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance
Office and online visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Online primary care doctor visit: LiveHealth Online	$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	Deductible, then 0% coinsurance
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Urgent care (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 20% 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 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 20% 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, 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]	$5 copay	0% coinsurance
Retail pharmacy tier 2[4]	$60 copay	0% coinsurance
Retail pharmacy tier 3[4]	50% coinsurance (up to $500 per script)	0% coinsurance
Retail pharmacy tier 4	50% coinsurance (up to $750 per script)	0% coinsurance
Physical and occupational therapy(limits apply)	$30 copay	Deductible, then 0% coinsurance

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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.

Plan name	Silver PPO Standard Pathway (5L3L)		
	Silver PPO Standard Pathway 73% CSR (5L3M)	**Silver PPO Standard Pathway 87% CSR (5L3N)**	**Silver PPO Standard Pathway 94% CSR (5L3P)**
Network name	Pathway	Pathway	Pathway
Plan includes out-of-network coverage?	Yes	Yes	Yes
Individual deductible[1]	$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	$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
Office visit: primary care physician (PCP)(Other office services may be subject to deductible and plan coinsurance)	$40 copay	$20 copay	$10 copay
Office and online visit: specialist (Other office services may be subject to deductible and plan coinsurance)	$60 copay	$45 copay	$30 copay
Online primary care doctor visit: LiveHealth Online	$40 copay	$20 copay	$10 copay
Diagnostic tests[2] (Ex. X-ray, EKG)	Deductible, then $40 copay	Deductible, then $30 copay	$25 copay
Advanced diagnostic tests[2] (Ex. MRI, CT scan)	$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 (Other office services may be subject to deductible and plan coinsurance)	$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 $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 $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 $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	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	$5 copay
Retail pharmacy tier 2[4]	$45 copay	$25 copay	$10 copay
Retail pharmacy tier 3[4]	$70 copay	$40 copay	$30 copay
Retail pharmacy tier 4	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	$20 copay	$20 copay

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MEDICAL AND SILVER COST-SHARING REDUCTION PLANS 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 Subscriber Agreement 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 for a 90 day supply are 3 times the retail copay for Tier 1, 2 and 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 do not have an affordable coverage option.

Δ The Tier 1 network has lower cost shares for many providers such as 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 Care on our website, anthem.com, and look for "Value Tier 1" or Participating Tier 2.

† For our BlueCare Prime network, referrals to specialists are required.

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 do not 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 (UR) is a program that is part of your health plan. It lets us make sure you are 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 is 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.

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 is how requesting precertification can help you:

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 is 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 are 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.

IMPORTANT LEGAL INFORMATION

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 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
- 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 lawNutritional 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 are not 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 2019, Anthem's Individual market segment MLR for state law purposes was 85.27% for HMO plans and 83.14% for PPO/Indemnity plans. For 2019, Anthem's MLR for federal law purposes was 86.7% 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 is important we treat you fairly

That is why we follow federal civil rights laws in our health programs and activities. We do not 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 is not 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 is 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)

GET HELP IN YOUR LANGUAGE

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)

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