2017 Plan Year: Indiana Individual and Family

Your Health Plan Guide

Bronze, Silver, Gold and Catastrophic plans

Anthem BlueCross BlueShield

Looking for a new health plan?
We can help.

03674INMENABS Rev. 4/17

Why Anthem?

Health plans don’t have to be complicated.

We understand that every individual and family is unique. That’s why we offer many affordable 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.
- Dedicated customer service.
- All your benefits, including dental and vision, from one source.
- Competitive pricing.
- Convenient online tools, including 24/7 access to doctors through LiveHealth Online.
- A simple enrollment process.
- 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 Indiana, that's our goal — through our networks and our experience.

* Based on Internal Data, 2016.

Table of Contents

Quick clicks

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

- Medical plans
- Networks
- Find a Doctor
- Prescriptions

What we cover

All our plan options have one major goal — to help you stay healthy and provide the quality coverage you need, when you need it.That's why, no matter which plan you choose, you're covered from preventive care to emergencies and plenty in between!

Built in benefits

Our plans include the essential health benefits (EHBs) mandated 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, network preventive care

With Anthem, you pay no copay, no coinsurance and no deductible for covered **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 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 non-network benefits, embedded dental benefits will also be available through non-network providers. If you choose a plan that only includes network benefits, the dental benefits will only be available through network providers. Remember, you save money when using 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. Here's what you need to know:

About our covered drug list

Anthem's pharmacy plans have a formulary/drug list, which is a list of covered prescription drugs that includes hundreds of brand name and generic medicines. Our individual and family plans use the Select Drug List, which offers drugs in every category and class that meet or exceed ACA requirements. The list tells you what tier your drug is in and provides guidance on how your cost shares are affected. Cost shares usually go up the higher the drug tier. Talk to your doctor about possible lower-cost options if your drug is in a higher tier.

Access all of your pharmacy information at anthem.com

- Find out if your medication is covered. Check out our Select Drug List at anthem.com/pharmacyinformation and click on the link, **Indiana Select Drug List (Searchable)**.
- See if your preferred pharmacy is in the plan's network. Visit anthem.com/pharmacyinformation and select the **Rx Networks** tab.
- Learn more about using your pharmacy benefits, your drug list and get answers to questions about prior authorization and step therapy. See our FAQs at anthem.com/faqs/indiana/pharmacy.

Together with medical – better and easier than ever

With our combined pharmacy and medical programs, your doctor has a better picture of your health which can help result in:

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

Save with prescription drug benefits

Anthem wants to help lower the cost of your prescription drugs, improve your overall health and deliver top-notch customer service. Here's how:

A retail pharmacy network with two coverage levels helps provide savings and access

Level 1	Level 2
Visiting CVS, Target, Wal-Mart, Kroger, Safeway, or any of our nearly 25,000 national Level 1 network pharmacies give you the lowest out-of-pocket costs for your prescriptions.	You can also visit one of our 50,000+ national Level 2 network pharmacies, and your prescriptions will be covered for an additional cost.†

Go to anthem.com/pharmacyinformation and select the **Rx Networks** tab to see if your preferred pharmacy is in Level 1 or Level 2. You'll save money by choosing a Level 1 pharmacy.

Save with home delivery

We offer home delivery of your medicines right to your door. With home delivery, you can have the medicines you take for ongoing conditions like indigestion, high blood pressure, high cholesterol or diabetes, delivered to your doorstep.

Home delivery makes it easy for you to stay on track with your medication therapy, helping reduce doctor visits and hospitalizations.

You may save time and money. With home delivery, you can receive up to a 90-day supply of medication, meaning less frequent refills and fewer trips to the pharmacy. Home delivery makes it easy for you to get your medicine quickly and safely.

* Outcomes based on 2014 integrated analysis. Results do not represent a guarantee of outcomes, group-specific results and cost savings will vary.
† Additional $10 copayment or 10% coinsurance may apply.

How to choose a plan

Networks...why choosing a doctor in your plan matters

One thing to think about when shopping for a health plan is your health plan's network of participating providers.

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 negotiate with that same doctor to discount the rate for our Anthem members down to $100. Once this agreement is made, the doctor becomes part of our network of health care providers.

Bottom line: If you have a favorite doctor, hospital or other health care provider, you should always check to see if that provider is in our network, so you can get the benefit of the discounted or network rate.

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 HMO/POS**) 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.

Types of networks: HMO and POS

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

- **Health maintenance organization (HMO):** With our HMO, you don't have to choose a primary care doctor to manage your care needs and a referral from your primary care doctor is not required to see other network doctors. Having a primary care doctor is still a good idea for things like checkups and any ongoing health issues. HMOs don't offer non-network benefits, except for emergency and urgent care or when a service is preapproved. If you go outside the network for any other reason, you'll have to pay 100% out of pocket.
- **Point of service (POS):** With our POS plan, you have the freedom to see any network doctor you choose without a referral. It's also a good idea to have a primary care doctor to coordinate your care, even though you're not required to pick one. Like a preferred provider organization (PPO), you can go out of network and pay a higher deductible, copay or coinsurance — you'll save more when you stay in the network.

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! You can access emergency or urgent care no matter where you are in the United States (U.S.).

Our plans cover medically necessary emergency and urgent care in all 50 states.

And, you can even use LiveHealth Online when you travel to most other states in the U.S. Visit livehealthonline.com/availability to see a map of availability by state. Please refer to Online tools for more information about LiveHealth Online.

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

Doctors in the plan: Doctors and other health care providers who contract with us to provide care at discounted rates.

Doctors outside the plan: Doctors and other health care providers who are not contracted with the health plan.

If you choose to go to a doctor not in your plan, you'll pay higher non-network rates with our POS plans and you'll pay 100% out of pocket with our HMO plans.

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 representative 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 click on the link, **Indiana 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 the Health Insurance 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 it?**
  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.

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 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 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 the Pathway HMO/POSPathway X HMO/POS network, he would have paid more.

Keep in mind if your plan doesn't include coverage for non-network benefits, you'll pay the full cost for services from doctors not in our network 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 representative for more information.

You can also visit **anthem.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.

Qualify for financial help?

With the Affordable Care Act (ACA), most people have to get health care coverage unless they qualify for an exemption. But you may be eligible for financial help to pay for your insurance.

Your medical plan may not cost as much as you think

Depending on your income and family size, you may qualify for an advance premium tax credit (APTC) on any metal level plan, excluding Catastrophic plans, when you buy a plan through the Health Insurance Marketplace. If you qualify, you may be able to enroll in certain Silver plans available on the Health Insurance Marketplace that offer a reduction in the deductible, copays and out-of-pocket costs charged under that plan. This is called a cost-share reduction (CSR) plan (also called cost-sharing subsidy). These options are shown in the chart below as S04, S05 and S06.

Use the chart below to see if you qualify for a cost-share reduction.

1. Find your family size. Then, figure out your yearly income and move across the row to find the income range that applies to your household.

2. Look at the percentage at the top of the chart to see where you fall on the Federal Poverty Level (FPL).

3. Go to the second row to find the plan you qualify for.*

2017 Federal Poverty Level

	Less than 138%		138% - 150%	151% - 200%	201% - 250%
You qualify for	Medicaid Eligible		S06	S05	S04
Family Size					
1	$11,880	$16,394	$16,395-$17,820	$17,821-$23,760	$23,761-$29,700
2	$16,020	$22,108	$22,109-$24,030	$24,031-$32,040	$32,041-$40,050
3	$20,160	$27,821	$27,822-$30,240	$30,241-$40,320	$40,321-$50,400
4	$24,300	$33,534	$33,535-$36,450	$36,451-$48,600	$48,601-$60,750
5	$28,440	$39,247	$39,248-$42,660	$42,661-$56,880	$56,881-$71,100
6	$32,580	$44,960	$44,961-$48,870	$48,871-$65,160	$65,161-$81,450
7	$36,730	$50,687	$50,688-$55,095	$55,096-$73,460	$73,461-$91,825
8	$40,890	$56,428	$56,429-$61,335	$61,336-$81,780	$81,781-$102,225

Source: Calculations based on data from the U.S. Department of Health and Human Services, www.federalregister.gov/documents/2016/01/25/2016-01450/annual-update-of-the-hhs-poverty-guidelines.

* Other metal level plans are available, but are not eligible for a cost-share reduction.

Avoid tax penalties

If you don't enroll in a medical plan, you may have to pay a penalty – unless you qualify for an exemption. Penalties are based on your income and increase each year for inflation. To learn how tax penalties could affect you, contact a tax advisor.

What does it mean to shop on or off the Marketplace?

The medical plans you see in this brochure are only available off the Health Insurance Marketplace (your state's Marketplace). If you don't qualify for an APTC or a Silver CSR plan, you may want to shop off the Marketplace at **anthem.com**. We have lots of plans to choose from, and we can help you find one just right for you.

Does the chart show you qualify for a Silver CSR plan? Then, you'll need to shop on the Health Insurance Marketplace. You can still buy an Anthem plan at **healthcare.gov**, where you can take advantage of an APTC or Silver CSR plan, if you qualify.

Whether you shop on or off the Marketplace, you can compare plans and get a quote on the plan that fits your needs.

Contact your Anthem representative and ask about our plans.

Overview of plans

Understanding insurance terms

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 *network* services only.**

For more information, contact your Anthem representative. 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 non-network coverage?	Indicates whether the plan includes coverage for non-network benefits. **Network** refers to doctors who are part of the Pathway HMO/POS network. **Non-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 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 Gold plans. **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 network 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 a health care provider. *For example:* If your copay is $50, then you pay $50 when you see your 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 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

Individual deductible, Individual out-of-pocket limit and coinsurance reflect Network / Non-network cost share information, if applicable for the plan. All other cost share information is for network services only.

	Anthem Bronze Pathway POS 5000 (1GFH)	Anthem Bronze Pathway 20% for HSA (1GFK)	Anthem Bronze Pathway 5850 (1XAD)
Network name	Pathway HMO/POS	Pathway HMO/POS	Pathway HMO/POS
Plan includes out-of-network coverage?	Yes	No	No
Individual deductible	$5,000 / $15,000 Network / Non-network	$5,100	$5,850
Individual out-of-pocket limit	$7,150 / $30,000 Network / Non-network	$6,550	$7,150
Coinsurance (percentage may vary for some covered services)	40% / 60% Network / Non-network	20%	30%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[2,3] (Other office services may be subject to deductible and plan coinsurance)	$50 copay per visit for the first 3 visits, then deductible and 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $500 copay and 50% coinsurance	Deductible, then $500 copay and 50% coinsurance	Deductible, then $300 copay and 50% coinsurance
Urgent care	Deductible, then $50 copay and 40% coinsurance	Deductible, then $50 copay and 20% coinsurance	Deductible, then $75 copay and 30% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then $500 copay and 40% coinsurance	Deductible, then $500 copay and 20% coinsurance	Deductible, then $500 copay and 30% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 50% coinsurance	Deductible, then 20% coinsurance	Deductible, then $1,000 copay and 50% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]**: level 1 / level 2**	40% coinsurance / 50% coinsurance	20% coinsurance / 30% coinsurance	30% coinsurance / 40% coinsurance
Retail pharmacy tier 2[4]**: level 1 / level 2**	40% coinsurance / 50% coinsurance	20% coinsurance / 30% coinsurance	30% coinsurance / 40% coinsurance
Retail pharmacy tier 3: level 1 / level 2	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Retail pharmacy tier 4: level 1 / level 2	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Speech therapy (limits apply)	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance
Office visit: chiropractic (limits apply)	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance

Please see Medical plans footnotes on page 17.

Medical plans

Individual deductible, Individual out-of-pocket limit and coinsurance reflect Network / Non-network cost share information, if applicable for the plan. All other cost share information is for network services only.

	Anthem Bronze Pathway 6000 (1GFG)	Anthem Bronze Pathway 0% for HSA (1GFJ)	Anthem Bronze Pathway 6400 (1GFF)
Network name	Pathway HMO/POS	Pathway HMO/POS	Pathway HMO/POS
Plan includes out-of-network coverage?	No	No	No
Individual deductible	$6,000	$6,100	$6,400
Individual out-of-pocket limit	$7,150	$6,550	$7,150
Coinsurance (percentage may vary for some covered services)	30%	0%	30%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[2,3] (Other office services may be subject to deductible and plan coinsurance)	$45 copay per visit for the first 3 visits, then deductible and 30% coinsurance	Deductible, then 0% coinsurance	$50 copay per visit for the first 2 visits, then deductible and 30% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance	Deductible, then 30% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance	Deductible, then 30% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $500 copay and 50% coinsurance	Deductible, then $450 copay	Deductible, then $450 copay and 50% coinsurance
Urgent care	Deductible, then $50 copay and 30% coinsurance	Deductible, then $50 copay	Deductible, then $50 copay and 30% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then $500 copay and 30% coinsurance	Deductible, then $200 copay	Deductible, then $450 copay and 30% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 50% coinsurance	Deductible, then 0% coinsurance	Deductible, then 30% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance	Deductible, then 30% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies
Retail Pharmacy tier 1[4]**: level 1 / level 2**	30% coinsurance / 40% coinsurance	0% coinsurance / 10% coinsurance	$20 copay / $30 copay
Retail pharmacy tier 2[4]**: level 1 / level 2**	30% coinsurance / 40% coinsurance	0% coinsurance / 10% coinsurance	$80 copay / $90 copay
Retail pharmacy tier 3: level 1 / level 2	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Retail pharmacy tier 4: level 1 / level 2	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance	Deductible, then 30% coinsurance
Speech therapy (limits apply)	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance	Deductible, then 30% coinsurance
Office visit: chiropractic (limits apply)	Deductible, then 30% coinsurance	Deductible, then 0% coinsurance	Deductible, then 30% coinsurance

Please see Medical plans footnotes on page 17.

Medical plans

Individual deductible, Individual out-of-pocket limit and coinsurance reflect Network / Non-network cost share information, if applicable for the plan. All other cost share information is for network services only.

	Anthem Bronze Pathway 6600 (1XAJ)	Anthem Silver Pathway 1850 (1GFP)	Anthem Silver Pathway 2500 (1GFM)
Network name	Pathway HMO/POS	Pathway HMO/POS	Pathway HMO/POS
Plan includes out-of-network coverage?	No	No	No
Individual deductible	$6,600	$1,850	$2,500
Individual out-of-pocket limit	$6,600	$7,150	$7,150
Coinsurance (percentage may vary for some covered services)	0%	20%	10%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[2,3] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coinsurance	$40 copay per visit for the first 3 visits, then deductible and 20% coinsurance	$40 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 0% coinsurance	Deductible, then $300 copay and 50% coinsurance	Deductible, then $300 copay and 50% coinsurance
Urgent care	Deductible, then 0% coinsurance	Deductible, then $50 copay and 20% coinsurance	Deductible, then $50 copay and 10% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then 0% coinsurance	Deductible, then $500 copay and 20% coinsurance	Deductible, then $500 copay and 10% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance	Deductible, then $500 copay and 50% coinsurance	Deductible, then $500 copay and 50% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]**: level 1 / level 2**	0% coinsurance / 0% coinsurance	$15 copay / $25 copay	$15 copay / $25 copay
Retail pharmacy tier 2[4]**: level 1 / level 2**	0% coinsurance / 0% coinsurance	$50 copay / $60 copay	$50 copay / $60 copay
Retail pharmacy tier 3: level 1 / level 2	0% coinsurance / 0% coinsurance	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Retail pharmacy tier 4: level 1 / level 2	0% coinsurance / 0% coinsurance	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance
Speech therapy (limits apply)	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance
Office visit: chiropractic (limits apply)	Deductible, then 0% coinsurance	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance

Please see Medical plans footnotes on page 17.

Medical plans

Individual deductible, Individual out-of-pocket limit and coinsurance reflect Network / Non-network cost share information, if applicable for the plan. All other cost share information is for network services only.

	Anthem Silver Pathway for HSA (1GFN)	Anthem Silver Pathway 3000 (1GFL)	Anthem Silver Pathway 4250 (1XA7)
Network name	Pathway HMO/POS	Pathway HMO/POS	Pathway HMO/POS
Plan includes out-of-network coverage?	No	No	No
Individual deductible	$2,700	$3,000	$4,250
Individual out-of-pocket limit	$5,000	$7,150	$5,750
Coinsurance (percentage may vary for some covered services)	10%	15%	25%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[2,3] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 10% coinsurance	$30 copay	$25 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 10% coinsurance	Deductible, then 15% coinsurance	$50 copay
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 10% coinsurance	Deductible, then 15% coinsurance	Deductible, then 25% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $300 copay and 50% coinsurance	Deductible, then $300 copay and 50% coinsurance	Deductible, then $300 copay and 50% coinsurance
Urgent care	Deductible, then $50 copay and 10% coinsurance	Deductible, then $50 copay and 15% coinsurance	$90 copay
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then $500 copay and 10% coinsurance	Deductible, then $500 copay and 15% coinsurance	Deductible, then 25% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then $500 copay and 50% coinsurance	Deductible, then $500 copay and 50% coinsurance	Deductible, then $500 copay and 50% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 10% coinsurance	Deductible, then 15% coinsurance	Deductible, then 25% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1: No deductible Tier 2, 3, 4: $1,000 Combined pharmacy deductible
Retail pharmacy tier 1[4]**: level 1 / level 2**	10% coinsurance / 20% coinsurance	$15 copay / $25 copay	$10 copay / $20 copay
Retail pharmacy tier 2[4]**: level 1 / level 2**	10% coinsurance / 20% coinsurance	$50 copay / $60 copay	$40 copay / $50 copay
Retail pharmacy tier 3: level 1 / level 2	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Retail pharmacy tier 4: level 1 / level 2	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 10% coinsurance	Deductible, then 15% coinsurance	Deductible, then 25% coinsurance
Speech therapy (limits apply)	Deductible, then 10% coinsurance	Deductible, then 15% coinsurance	Deductible, then 25% coinsurance
Office visit: chiropractic (limits apply)	Deductible, then 10% coinsurance	Deductible, then 15% coinsurance	Deductible, then 25% coinsurance

Please see Medical plans footnotes on page 17.

Medical plans

Individual deductible, Individual out-of-pocket limit and coinsurance reflect Network / Non-network cost share information, if applicable for the plan. All other cost share information is for network services only.

	Anthem Silver Core Pathway 5100 (2EQK)	Anthem Gold Pathway 1250 (1GFQ)	Anthem Catastrophic Pathway 7150 (1GER)
Network name	Pathway HMO/POS	Pathway HMO/POS	Pathway HMO/POS
Plan includes out-of-network coverage?	No	No	No
Individual deductible	$5,100	$1,250	$7,150
Individual out-of-pocket limit	$6,600	$6,200	$7,150
Coinsurance (percentage may vary for some covered services)	25%	10%	0%
Preventive care[1]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[2,3] (Other office services may be subject to deductible and plan coinsurance)	$35 copay	$30 copay	$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $300 copay and 50% coinsurance	Deductible, then $300 copay and 50% coinsurance	Deductible, then 0% coinsurance
Urgent care	Deductible, then $50 copay and 25% coinsurance	Deductible, then $50 copay and 10% coinsurance	Deductible, then 0% coinsurance
Emergency room care (Copay waived if admitted into the hospital from the emergency room.)	Deductible, then $500 copay and 25% coinsurance	Deductible, then $500 copay and 10% coinsurance	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then $500 copay and 50% coinsurance	Deductible, then $500 copay and 50% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 0% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tier 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]**: level 1 / level 2**	$10 copay / $20 copay	$10 copay / $20 copay	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2[4]**: level 1 / level 2**	$40 copay / $50 copay	$40 copay / $50 copay	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3: level 1 / level 2	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance
Retail pharmacy tier 4: level 1 / level 2	40% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance	0% coinsurance / 0% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 0% coinsurance
Speech therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 0% coinsurance
Office visit: chiropractic (limits apply)	Deductible, then 25% coinsurance	Deductible, then 10% coinsurance	Deductible, then 0% coinsurance

Please see Medical plans footnotes on page 17.

Medical plans benefit footnotes

1 Nationally recommended **preventive care services** from 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.
2 **LiveHealth Online** web visits have the same PCP office visit cost share listed in the chart.
3 For plans with a **Retail 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 2.5 times the retail copay for Tier 1 drugs and 3 times the retail copay for Tier 2 drugs when the plan has retail pharmacy copays.

Dental

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

- Dental Prime*
- Anthem Dental Family Value
- Anthem Dental Family
- Anthem Dental Family Enhanced

Anthem can help you get access to the dental care you need for your overall health. Many of our dental plans cover you 100% for exams, cleanings and X-rays. Plus, we have one of the largest dental preferred provider organization (PPO) networks in the country. To see more of what we cover, take a look at our **Dental stand-alone plans** on the next page.

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 the web address on your ID card 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.

Vision

You can add Blue View Vision℠ benefits to any Anthem medical or dental plan. These plans feature:

- **A broad national network** — More than 33,000 participating private practice doctors† at over 26,000 locations, including online choices at Glasses.com, ContactsDirect or 1-800 CONTACTS plus leading retail stores like LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and most Pearle Vision® locations — these stores offer evening and weekend hours.
- **Value-added savings**§ — 15% to 40% off unlimited purchases of most extra pairs of eyewear, conventional contact lenses, lens treatments and more — even after you've used all of your covered benefits.

	Benefit frequency	Cost Share
Eye exam (with dilation as needed)	Once every 12 months	$20 copay
Standard plastic (CR39) lenses:±	Once every 24 months	
Single vision		$20 copay
Bifocal		$20 copay
Trifocal		$20 copay
Contact lenses:	Once every 24 months	
Elective (conventional and disposable)		$80 allowance
Non-elective		Covered in full
Frames	Once every 24 months	$130 allowance

± Factory scratch coating is covered at no extra cost. Polycarbonate and Transitions lenses are covered for dependents.

The medical + dental + vision advantage

Coordinating medical, dental and vision 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.

* Does not include ACA required pediatric dental essential health benefits coverage.
† Blue View Vision internal data, 2015.
§ Laws in some states may prohibit network providers from discounting products and services that are not covered benefits.

Dental stand-alone plans

	Anthem Dental Family Value (Dependents age 18 and younger)	**Anthem Dental Family Value** (Adults age 19+)	**Anthem Dental Family** (Dependents age 18 and younger)	**Anthem Dental Family** (Adults age 19+)	**Anthem Dental Family Enhanced** (Dependents age 18 and younger)	**Anthem Dental Family Enhanced** (Adults age 19+)
	Network / Non-network	**Network / Non-network**	**Network / Non-network**	**Network / Non-network**	**Network / Non-network**	**Network / Non-network**
Dental network	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime	Dental Prime
Deductible (per person, all services)	$50	$50	$50	$50	$25	$50
Annual Maximum (per person)	None	$750	None	$750	None	$1,000
Annual out-of-pocket limit	$350[1] / None	None	$350[1] / None	None	$350[1] / 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% / 30% coinsurance	0% / 50% coinsurance	0% / 30% coinsurance	0% / 50% coinsurance	0% / 20% coinsurance	0% / 50% coinsurance
Extra cleaning	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
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% / 50% coinsurance	50% / 75% coinsurance	40% / 50% coinsurance	50% / 75% coinsurance	20% / 40% coinsurance	20% / 60% coinsurance
Brush biopsy	Not covered	Covered	Not covered	Covered	Not covered	Covered
Complex & major services	No waiting period	Not covered	No waiting period	12-month waiting period	No waiting period[2]	12-month waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	70% / 85% coinsurance	20% / 50% coinsurance	50% / 75% coinsurance
Prosthetics (crowns, dentures, bridges)	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	70% / 85% coinsurance	50% / 50% coinsurance	50% / 75% 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	50% / 50% coinsurance[3]	Not covered
International emergency dental program	Included	Included	Included	Included	Included	Included
Blue View Vision	Available	Available	Available	Available	Available	Available

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

1 Per child, up to $700 per family.
2 Except 12-month waiting period for **Cosmetic orthodontia**.
3 $1,000 lifetime maximum for **Cosmetic orthodontia.**

Dental stand-alone plans

	Dental Prime Plan A	Dental Prime Plan B	Dental Prime Plan C
	Network / Non-network	**Network / Non-network**	**Network / Non-network**
Dental network	Dental Prime	Dental Prime	Dental Prime
Deductible (per person, all services)	None	$50	$50
Annual Maximum (per person)	$500	$1,000	$1,250
Annual out-of-pocket limit	None	None	None
Diagnostic and preventive	No waiting period	No waiting period	No waiting period
Cleaning, exams and x-rays	0% / 0% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance
Extra cleaning	1 extra cleaning per year for those who are pregnant or diabetic	1 extra cleaning per year for those who are pregnant or diabetic	1 extra cleaning per year for those who are pregnant or diabetic
Basic services	Not covered	6-month waiting period	6-month waiting period
Fillings	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
Brush biopsy	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
Complex & major services	Not covered	12-month waiting period	12-month waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	Not covered	50% / 50% coinsurance	50% / 50% coinsurance
Prosthetics (crowns, dentures, bridges)	Not covered	Not covered	50% / 50% coinsurance
Medically necessary orthodontia	Not covered	Not covered	Not covered
Cosmetic orthodontia	Not covered	Not covered	Not covered
International emergency dental program	Included	Included	Included
Blue View Vision	Available	Available	Available

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

1 Per child, up to $700 per family.
2 Except 12-month waiting period for **Cosmetic orthodontia**.
3 $1,000 lifetime maximum for **Cosmetic orthodontia.**

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

To view all our SpecialOffers discounts, log in to **anthem.com** and select **Discounts**.

* 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 (EHPC) 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.‡

Register at anthem.com for online access.

Once you're a member, register 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** for any current health insurance plans covering members of your household
3. **Name of every job-based health insurance plan** for which you or someone in your household is eligible

Then, you can:

4. **Call your Anthem representative** to enroll or learn more about our health care plans. Take a look at the application included with this brochure.
5. **Visit our website** at anthem.com and apply online.

Generally, plans can be purchased once a year through an open enrollment period. This year, the open enrollment period runs from November 1, 2016 through January 31, 2017. Be sure to enroll by December 15, 2016, to start coverage effective January 1, 2017.

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

Your Anthem representative can help you enroll. You can also apply online at anthem.com.

Simplified payments

You can set up a recurring payment using electronic funds transfer (EFT) or bank draft, which means your premium will automatically be paid from your bank account each month.

You can also use WebPay to make your monthly payments. This payment program allows you to enroll in automatic recurring payments with a Visa or MasterCard debit or credit card.

If you choose to make regular credit card payments, make sure your card's expiration date and other account information stays up to date.

We want you to be satisfied

After you enroll in one of our plans, you'll have access to a *Contract* that explains the terms and conditions of coverage, including exclusions and limitations. You'll have 10 days to examine your *Contract'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 *Contract* may be continued in force or discontinued. For more complete details on what's covered and what isn't:

- Review the *Contract*.
- Call your Anthem representative.
- Go to **anthem.com**.

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

The health plans described in this document aren't eligible for a premium tax credit or subsidy/cost-sharing assistance. The Affordable Care Act (ACA) helps people with low or modest incomes pay for their health insurance with a premium tax credit or subsidy. You can only get financial help if you're eligible and you buy your individual health coverage through the Health Insurance Marketplace.

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 your Anthem representative. 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 resident of the State of Indiana and not entitled to or enrolled in Medicare. Family health coverage includes you, your spouse or domestic partner and any dependent children. Children are covered to the end of the month in which they turn age 26.

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 the Health Insurance Marketplace 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

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

Special Enrollment and Changes Affecting Eligibility

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

Depending on the event which 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 calendar year. The actual effective date is determined by the date Anthem receives a complete application with the applicable premium payment.

Grievances and Appeals Process

You can learn more about our grievance and appeals process at the Indiana Department of Insurance website: http://www.in.gov/idoi/3008.htm.

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 a 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 a network doctor. If you choose a non-network provider, be sure to call us to see if you need prior authorization. Non-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.

Network Providers

Network providers are the key to providing and coordinating your health care services. The broadest benefits are provided for services obtained from a primary care physician (PCP), specialty care physician (SCP), or other network providers.

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

For services rendered by network providers:

- You will not be required to file any claims for services you obtain directly from network providers. Network providers will seek compensation for covered services rendered from Anthem and not from you except for approved copayments/coinsurance and/or deductibles. You may be billed by your network provider(s) for any non-covered services you receive or where you have not acted in accordance with the Contract.
- Health Care Management is the responsibility of the network provider.

If there is no network provider who is qualified to perform the treatment you require, contact Anthem prior to receiving the service or treatment and Anthem may approve a non-network provider for that service as an authorized service. Non-network providers are described below.

Non-network Providers

With the exception of Anthem Bronze Pathway POS 5000 (1GFH) your health care plan does not cover benefits for services received from non-network providers unless the services are:

1. To treat an emergency medical condition;
2. Urgent care; or
3. Authorized by Anthem.

Services will only be covered services if rendered by providers located in the State of Indiana unless:

- The services are for emergency care, urgent care or emergency ambulance services as specified in the Contract; or
- The services are approved in advance by Anthem.

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

For services rendered by a non-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.

Exclusions and Limitations

Please see your Contract for details.

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 Anthemfor 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 additional cost by calling the Member Services number (855-330-1093). (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 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 (855-330-1093). (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 (855-330-1093). (TTY/TDD: 711)

Burmese
ဤစာရွက်စာတမ်းကို နားလည်သဘောပေါက်ရန် အခြားဘာသာစကား တစ်မျိုးမျိုးဖြင့် သင်လိုအပ်ပါက အခကြေးငွေ ထပ်မံပေးအပ်စရာ မလိုပဲ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန ဖုန်းနံပါတ် (855-330-1093) သို့ ခေါ်ဆိုကာ တောင်းခံနိုင်ပါသည်။ (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(855-330-1093)請求免費協助。(TTY/TDD: 711)

Dutch
Als u hulp nodig heeft om dit document te begrijpen in een andere taal, mag u daar zonder aanvullende kosten om vragen door te bellen met het ledenservicenummer (855-330-1093). (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 : 855-330-1093. (TTY/TDD: 711)

German
Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (855-330-1093). (TTY/TDD: 711)

Hindi
अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-330-1093) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

Japanese
この書面を他の言語で理解するための支援が必要な場合には、メンバーサービス番号（855-330-1093）に電話して支援を求めることができます。追加費用はかかりません。(TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-330-1093)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Pennsylvania Dutch
Wann du Helfe brauchscht um selle Document zu verschtehe in en annere Schprooch, du kannscht fer sell frooge um nix zu bezaahle. Ruff Member Services Nummer (855-330-1093) aa. (TTY/TDD: 711)

Punjabi
ਜੇ ਤੁਹਾਨੂੰ ਕਿਸੇ ਬਦਲਵੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਸਮਝਣ ਲਈ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ ਤੁਸੀ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ (855-330-1093) ਤੇ ਕਾਲ ਕਰਕੇ ਕਿਸੇ ਵਾਧੂ ਲਾਗਤ ਦੇ ਬਿਨਾਂ ਇਸ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। (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 (855-330-1093). (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 (855-330-1093). (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 (855-330-1093). (TTY/TDD: 711)

Anthem BlueCross BlueShield

Get help today!

To learn more, call your Anthem representative. 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 your Anthem representative.

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.**

Information for Applicants Requesting a Special Enrollment Period

Anthem BlueCross BlueShield

When applying to enroll for coverage during a Special Enrollment Period (SEP), an applicant must be eligible to enroll and provide supporting documentation of a qualifying event. Without this documentation the applicant may not be able to enroll.

Please review the list below which outlines examples of what may be used as supporting documentation. Be sure to send in a copy of the documentation supporting the qualifying event when the completed application is submitted or upload a copy of the documentation when submitting an online application.

For paper applications, please submit legible copies of everything and keep all original documents for your personal records, because no documentation will be returned. Please write the applicant's name on the top of each page of the supporting documentation.

After reviewing the information provided, we may request additional documentation to confirm eligibility. Please note that loss of health coverage due to fraud, intentional misrepresentation of a material fact or failure to pay a premium do not constitute qualifying events.

Supporting documentation by type of qualifying event
OFF Exchange for all SEP applicants for Anthem Blue Cross and Blue Shield plans in CT, IN, KY, ME, MO, NH, NV, OH or WI

Qualifying event	Description and examples of required supporting documentation
Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay a premium	**Loss of Minimum Essential Coverage due to change in employment status:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals) and reason for loss of Minimum Essential Coverage (i.e., reduction in employment hours, etc.), **or** • Letter that provides notice of **offer** of COBRA or state continuation benefits **Loss of Minimum Essential Coverage due to loss of dependent eligibility status:** **Due to death:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals), and • Copy of death certificate or obituary **Due to Medicare eligibility:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals), and • Copy of Medicare card or approval letter from Social Security **Due to an over-age dependent:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals) **Due to legal separation, divorce, dissolution of domestic partnership:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals), and • Divorce decree, legal separation agreement, or notarized/legal termination of domestic partnership **Loss of Minimum Essential Coverage due to exhaustion of COBRA or state continuation benefits:** • Letter that provides notice of termination of COBRA or state continuation benefits

Qualifying event	Description and examples of required supporting documentation
Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay a premium	**Loss of Minimum Essential Coverage due to (permanent) move to new service area:** *Note: Applicant must have had Minimum Essential Coverage for one or more days in the 60 days prior to the permanent move, unless he or she is moving from a foreign country or a United States territory (See below).* • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming loss of coverage (date and individuals) **and** • Documentation of applicant's old address and new address (if not present on employer letter or previous carrier documentation) which may be validated by any of the following: — Recent utility bill (electric, water, phone, internet, cable) — Signed residential lease, rental agreement/contract, mortgage or nursing home/assisted living facility residency documentation — A deed showing applicant ownership of property in the new service area — New driver's license with new address in the service area — Receipt of property tax paid — Insurance documents, such as homeowner's, renter's, or life insurance policy or statement — Mail from the Department of Motor Vehicles, such as a driver's license, vehicle registration, or change of address card — State ID — Official school documents, including school enrollment, report cards, or housing documentation — Mail from a government agency to your address, such as a Social Security statement, or a notice from TANF or SNAP agency — Mail from a financial institution, such as a bank statement — U.S. Postal Service change of address confirmation letter — Pay stub showing address — Voter registration card showing name and address — Moving company contract or receipt showing address — Document from the Department of Corrections, jail, or prison indicating recent release or parole, including an order of parole, order of release, or an address certification — If you are homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify your residency. This person must prove their own residency by including one of the documents listed above. — If you are living in the home of another person, like a family member, friend, or roommate, a letter/statement from that person stating you are living with them. This person must prove their own residency by including one of the documents listed above. — Letter from a local non-profit social services provider, certified application counselor, navigator or federally qualified health center that can verify your address. If you are homeless, you can provide a letter from a government entity or not-for-profit organization, including shelters, verifying your address. — Consumers living in rural areas may provide a rural route mail delivery address. The supporting documentation needs to include the name of the applicant along with the residential address listed on the application (the new address), and documentation of the previous address, which should include the applicant's name and the residential address before the move. For **child only applications**, the name of the parent/guardian in the signature section of the application must match the name on the supporting documentation.

Qualifying event	Description and examples of required supporting documentation
Legal guardianship or court order	Legal documentation of guardianship that indicates the subscriber or the subscriber's spouse is a guardian of the applicant or court order that indicates the subscriber is required to cover the applicant. For KY only: May apply when application filed with the court for guardianship. Contact us if you are applying for a child only policy.
Gain or become a dependent through birth or adoption/ placement for adoption	**Birth:** Birth certificate **or** medical records from hospital or pediatrician which indicate the names of the parents, the name of the baby, and date of birth. *NOTE: For current Anthem members, a mother's delivery claim may be considered as supporting documentation.* **Adoption/placement for adoption:** Adoption certificate or document establishing placement of a child with applicant for adoption.
Gain a dependent through marriage or domestic partnership	Certificate of marriage, domestic partnership
Applicants moving to the U.S. from a foreign country or U.S. territory	∘ Documentation of the move (including date of move) which may be validated by a passport, VISA, or airplane ticket **and** ∘ Documentation of the new address which may be validated by any of the following: — Signed residential lease, rental agreement/contract, mortgage — A deed showing applicant ownership of property in the new service area — If you are homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify your residency. This person must prove their own residency by including one of the documents listed above. — If you are living in the home of another person, like a family member, friend or roommate, a letter/statement from that person stating you are living with them. This person must prove their own residency by including one of the documents listed above. — Letter from a local non-profit social services provider, certified application counselor, navigator, or federally qualified health center that can verify your address. If you are homeless, you can provide a letter from a government entity or not-for-profit organization, including shelters, verifying your address. ∘ **And** one additional supporting document of new address which may be validated by one of the following in the applicant's name: — Recent utility bill (electric, water, phone, internet, cable) — New driver's license with new address in the service area — Receipt of property tax paid — Insurance documents, such as homeowner's, renter's, or life insurance policy or statement — Mail from the Department of Motor Vehicles, such as a driver's license or vehicle registration — State ID — Official school documents, including school enrollment, report cards, or housing documentation — Mail from a government agency to your address, such as a Social Security statement, or a notice from TANF or SNAP agency — Mail from a financial institution, such as a bank statement — Pay stub showing address or letter/employment contract from employer — Voter registration card showing name and address — Moving company contract or receipt showing address

Qualifying event	Description and examples of required supporting documentation
Release from incarceration	Papers from local, state or federal department of corrections or prisons showing the applicant's date of legal discharge.
Death of a family member enrolled under current coverage	• Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming coverage (date and individuals), **and** • Copy of death certificate or obituary
An individual, who was not previously a citizen, a national, or a lawfully present individual, gains such status	Change in status validated by any of the following: • Valid U.S. passport or passport card. • Valid I-551, permanent resident card (issued by the Department of Homeland Security/ U.S. citizenship and immigration services). Non-expiring I-551 (issued 1977-1989) cards are acceptable. • U.S. Certificate of Naturalization (federal form N-550). • Certificate of U.S. Citizenship (federal form N-560). • Employment Authorization Document. • Unexpired foreign passport with a valid unexpired U.S. visa affixed accompanied by the approved I-94 form documenting the applicants most recent admittance into the U.S.
Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events	Letter from applicant and an official form such as a letter or other supporting documentation from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected.

If you have further questions about qualifying events or the supporting documentation that is required, please call your agent or the number the number listed for your state below:

CT 1-855-837-8537
IN 1-855-330-1093
KY 1-855-330-1095
ME 1-855-330-1097
MO 1-855-330-1099
NH 1-855-330-1102
NV 1-855-330-1217
OH 1-855-330-1106
WI 1-855-330-1215

Anthem BlueCross BlueShield

Primary applicant name: _____

Welcome

Indiana Individual Application

Thanks for choosing us. We're glad you're here.

If you have any questions while filling out this form, give us a call at 1 (877) 212-1793. But if you've worked with an agent or broker, contact them first.

About this form

Use this form to apply for **new** medical, dental or vision coverage or to **change** existing coverage with Anthem Blue Cross and Blue Shield (Anthem).

You can apply or change coverage:

1. **During the annual Open Enrollment period**
   The earliest your coverage can start is the 1st of the year. Your coverage will start based on when we receive your complete application (including payment). If we get it:
   - Between the 1st and 15th day of the month, coverage is effective the 1st day of the following month.
   - Between the 16th and last day of the month, coverage is effective the 1st day of the second following month.
2. **Due to a qualifying event** (such as getting married, having a baby, etc.)
   When you're done with this form, fill out **Appendix A: Special Enrollment,** which includes information about when coverage starts.
3. **Any time** (for new dental coverage)
   You can apply for new dental coverage any time during the year.

Tips when filling out this form

1. Answer all questions. Please print clearly using blue or black ink only.
2. You can also apply online at **anthem.com**.
3. Refer to your Health Plan Guide for plan and enrollment details. Don't have a copy? Ask your agent or contact us.

Some Frequently asked questions

1. **Do I need to include a payment?**
   Yes. If applying for new coverage, we can't complete your application without your first month's premium payment. Without it, your enrollment will be delayed. Don't worry though – we won't charge your card or cash your check until you've been enrolled.
   If you're already a member, we need your payment before the requested effective date for your change.
2. **What if I already have coverage with another company?**
   Don't cancel your other coverage yet – your health coverage is too important. We'll contact you when you're approved. Then you'll need to cancel your other coverage.
3. **Why do you need my Social Security Number?**
   The IRS requires us to collect it. It won't be shared unless required by law. If you enroll in a health savings account (HSA) compatible plan with us, we'll give it to our HSA banking partner.

Step 1: Who is applying?

Primary Applicant ☐ New coverage ☐ Change coverage ☐ Add dependent to existing coverage ID No. _____

Last Name (Legal Name)	**First Name** (Legal Name)	**M.I.**	**Social Security Number**

Marital status ☐ Single ☐ Married	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)	**Legal resident of IN:** ☐ Y ☐ N **US Citizen or National:** ☐ Y ☐ N	**County** (for home address)	**Tobacco use*** ☐ Yes ☐ No

Home address	**City**	**State**	**ZIP**
Billing address (optional - if different than your home)	**City**	**State**	**ZIP**
Mailing address (optional - if different than your home)	**City**	**State**	**ZIP**

Primary phone	**Secondary phone**	**Email address**
Preferred written language ☐ English (ENG) ☐ Spanish (SPA)		**Preferred spoken language** ☐ English (ENG) ☐ Spanish (SPA)

Spouse or Domestic partner

Last Name (Legal Name)	**First Name** (Legal Name)	**M.I.**	**Social Security Number**

Relationship to applicant ☐ Spouse ☐ Domestic partner	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)	**Legal resident of IN** ☐ Yes ☐ No	**US Citizen or National** ☐ Yes ☐ No	**Tobacco use*** ☐ Yes ☐ No

Child dependent Children must be under age 26.

Last Name (Legal Name)	**First Name** (Legal Name)	**M.I.**	**Social Security Number**

Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)	**Legal resident of IN** ☐ Yes ☐ No	**US Citizen or National** ☐ Yes ☐ No	**Tobacco use*** ☐ Yes ☐ No

Child dependent

Last Name (Legal Name)	**First Name** (Legal Name)	**M.I.**	**Social Security Number**

Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)	**Legal resident of IN** ☐ Yes ☐ No	**US Citizen or National** ☐ Yes ☐ No	**Tobacco use*** ☐ Yes ☐ No

Child dependent ☐ **Check here if you have more dependents**. Print an extra copy of this page and attach to your application.

Last Name (Legal Name)	**First Name** (Legal Name)	**M.I.**	**Social Security Number**

Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)	**Legal resident of IN** ☐ Yes ☐ No	**US Citizen or National** ☐ Yes ☐ No	**Tobacco use*** ☐ Yes ☐ No

*Tobacco use is the use of tobacco products 4 or more times per week, on average, in the last 6 months (excluding religious or ceremonial reasons).

Eligibility

Are any applicants eligible for Medicare?
☐ No ☐ Yes **If yes, who?**

Are any applicants currently incarcerated (with more than 60 days left to serve before release) as a result of a conviction? (not just pending disposition of charges)
☐ No ☐ Yes **If yes, who?**

Are any applicants currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits?

☐ No ☐ Yes **If yes,** fill out the boxes below.

Who	Reason	Start date of benefits	End date of benefits

Step 2: What coverage would you like?

Medical Plans

Choose only one medical plan.

Anthem Bronze	Anthem Silver	Anthem Gold
☐ Pathway 0% for HSA (1GFJ) ☐ Pathway 20% for HSA (1GFK) ☐ Pathway 5850 (1XAD) ☐ Pathway 6000 (1GFG) ☐ Pathway 6400 (1GFF) ☐ Pathway 6600 (1XAJ) ☐ Pathway POS 5000 (1GFH)	☐ Pathway for HSA (1GFN) ☐ Pathway 1850 (1GFP) ☐ Pathway 2500 (1GFM) ☐ Pathway 3000 (1GFL) ☐ Pathway 4250 (1XA7) ☐ Core Pathway 5100 (2EQK)	☐ Pathway 1250 (1GFQ)

Anthem Catastrophic Only available to applicants under age 30, unless otherwise qualified.

☐ Pathway 7150 (1GER)

Health Savings Account (HSA) Enrollment If you chose an HSA compatible plan, you have the option to setup a health savings account.

☐ Yes, I'd like to establish an HSA with Anthem's banking partner. (Please make sure you entered Social Security numbers in Step 1)

Current (existing) medical coverage If you already have health care coverage, please don't cancel it until you are effective with us.

☐ One or more of the applicants currently have health care coverage (Please fill out the info below)

People with coverage (Write ALL if everyone)	**Existing health care coverage company**	**Effective date** (When coverage started)
Type of coverage ☐ Group ☐ Individual	**ID number(s)**	**Last date of coverage** (If applicable)

Dental Plans

Dental coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a dental plan and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Dental plan options

☐ Anthem Dental Family Value (2J52)
☐ Anthem Dental Family (1FSD)
☐ Anthem Dental Family Enhanced (1FSE)
☐ Prime Plan A (1RBX)
☐ Prime Plan B (1RBY)
☐ Prime Plan C (1RBZ)

Existing dental coverage It's important we know.

☐ I currently have dental coverage (please fill out the info below)

People with coverage (write ALL if everyone applying):

Existing dental coverage company:	**Effective date** (when this coverage started)
ID Number:	**Last date of coverage** (if applicable)

Applicants for dental plan Check all that apply (Primary applicant must be included)

☐ Primary applicant ☐ Spouse or domestic partner ☐ All dependent children

Vision Plan	You must enroll in medical and/or dental coverage to be eligible for vision coverage.

Vision coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a vision plan and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Vision plan option		Applicants for vision plan	Check all that apply (Primary applicant must be included)
☐ Blue View Vision Individual (1RY4)		☐ Primary applicant ☐ Spouse or domestic partner ☐ All dependent children	

Step 3: Please read and sign

Important legal information

I understand that:

- I must send my first (initial) premium with this application, but it does not mean coverage has been approved. I'm applying for the coverage I chose on this form. To the extent permitted by law, Anthem has the right to accept or decline this application, and that there are no guarantees of any kind just because I filled out this form. If my application is denied, my bank account or credit card will not be charged.
- I'm responsible to let Anthem know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- Anthem may change check payments to electronic Automated Clearinghouse (ACH) debit transactions. If this happens, my original check will be destroyed. This charge will appear on my bank statement but my check won't be given to my financial institution or sent back to me. This charge will not enroll me in any Anthem automatic debit process and will only occur each time I send a check to Anthem. Any resubmissions due to insufficient funds may also occur electronically. All checking transactions will remain secure, and my payment by check means I agree to these terms.
- I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
- I'm applying for individual health and/or dental and/or vision coverage which is not part of any employer sponsored plan. I certify that neither I nor any dependent is being reimbursed or compensated for this coverage by any employer. I'm responsible for all of the premium payments and making sure that all premiums are paid.
- By signing below, I (primary applicant) agree to receive my plan-related communications either by email or electronically. This may include my contract, evidence of coverage, billing and explanation of benefits statements, or helpful information to get the most out of my plan. I agree to provide and update Anthem with my current e-mail address. I know that at any time I can change my mind and request a free copy of these materials by mail, by contacting Anthem.
- I certify that each Social Security number listed on this application is correct.
- My domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is mentally competent; he or she is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
- I acknowledge that I have read the Important Legal Information section, and I agree to the coverage conditions. I state that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s)

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative. This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

Please sign below

	Primary Applicant (or legal representative)	Date
	Spouse / Domestic Partner (or legal representative)	Date
	Dependent Child (age 18 or over)	Date
	Dependent Child (age 18 or over)	Date
	Dependent Child (age 18 or over)	Date

Did an agent help you? Make sure they fill out this section.

Agent (or broker) Certification	I certify to the best of my knowledge, the responses herein are accurate.			
Agent/Broker Signature				**Date**
Agent Name (Please print clearly)		**Agent TIN / SSN** (Encrypted TIN is ok)		**Agency or Parent TIN/ID**
Agent Address		**City**	**State**	**ZIP**
Agent Phone No.	**Agent Fax No.**	**Agent Email**		

Here's what's next.

1) Can you check a few items? When incorrect, they're the most frequent reasons for delays in enrollment.
   - Your name and address information should be clear and readable
   - You've included your first month's premium payment
   - Everyone 18 and older signed this form
   - If enrolling due to a qualifying event, you've completed Appendix A: Special Enrollment

2) All good? Send this to us by mail to Anthem Blue Cross and Blue Shield, P.O. Box 659806, San Antonio, TX 78265-9106 or by fax to 1 (800) 848-2512.

3) We'll be in touch in the next few weeks. If you have questions before then, call us at 1 (855) 330-1093.

Thank you!

Appendix A: Special Enrollment

If you're applying for coverage due to a qualifying event, please fill out this section along with your application.

Qualifying event date	
Date of qualifying event	For Loss of Coverage, this is the last date of existing or prior coverage. For all other events, please enter the date based on the qualifying event.

You must apply for coverage within 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
☐ **1. Marriage or Domestic Partnership** Got married or in a domestic partnership that becomes eligible for coverage (see step 3 for description of eligibility)	First day of the month after we receive your complete application
☐ **2. Birth or Adoption** Had a baby, adoption of a child or placement of a child with you for adoption	**Select an effective date:** ☐ Same as the event date ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application* ☐ First day of month after the event date
☐ **3. Court Order or Guardianship** Required by a court order to provide an eligible child(ren) coverage, including a child support order or appointment of guardianship of a child	**Select an effective date:** ☐ Same as the event date ☐ Based on when we receive your complete application*
☐ **4. Death** Death of a family member enrolled under current coverage	**Select an effective date:** ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application*
☐ **5. Immigration** Immigration status changed ☐ **6. Other qualifying event** If you can't find your situation, contact your agent/broker or call us. We can only enroll based on events defined by state and/or federal law.	Based on when we receive your complete application*

You must apply for coverage within 60 days before or 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
7. Loss of coverage: Lost or will lose Minimum Essential Coverage: ☐ Involuntary loss of coverage (for any reason except non-payment of premium or fraud) ☐ A legal separation or divorce ☐ Moved to a new service area. Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move.	First day of the month after we receive your complete application
☐ **8. Permanent Move** Moved to U.S. from a foreign country or a U.S. territory ☐ **9. Non-calendar renewal** Current policy does not renew on a calendar year basis (renews on a date other than January 1) ☐ **10. Jail or prison** Released from jail or prison (incarceration)	Based on when we receive your complete application*

* If the coverage date is based on when we receive your complete application, then if we receive it:
- Between the 1st and 15th day of the month, coverage is effective the 1st day of the following month.
- Between the 16th and the last day of the month, coverage is effective the 1st day of the second following month.

Almost there! We need a bit more info.

We need supporting documentation for your qualifying event, such as a letter or official form from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected. If you're applying because you've lost your coverage, we need to know the reason why coverage was lost, and it must be included in the supporting documentation. In all instances, we might need additional documentation to confirm eligibility.

Give us or your agent a call if you have any questions.

Payment Methods for Individual Applications

Anthem BlueCross BlueShield

Applicant/Member name	Primary applicant's Social Security number

Anthem Blue Cross and Blue Shield (Anthem) will accept monthly payments made on behalf of applicants/members **if the payment is made by the following persons or entities:** The Ryan White HIV/AIDS Program; other federal and state government programs that provide monthly payments and cost-sharing support for specific individuals; Indian tribes, tribal organizations and urban Indian organizations; or a relative or legal guardian on behalf of an applicant/member.

Unless required by law, Anthem does not accept monthly payments from third parties that are not listed above. Examples of third parties from whom Anthem will not accept monthly payments include, but are not limited to, insurance brokers and/or agents, providers, hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entities with a direct or indirect financial interest in the benefits of the contract/policy and employers that offer coverage under an employer health plan. Note: As allowed by law, Anthem reserves the right to decline monthly payments from third parties.

All payments will be debited (taken out of my bank account) or charged to my credit/debit card the day that my coverage is approved. By signing this form, I understand that the amount of the first payment may change from what I was told because my coverage has not been approved yet. In addition, I understand that my future payments may vary as a result of change(s) I make once enrolled, including but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified according to my plan/policy. I agree that Anthem has the right to debit/charge my bank account/card in the same way as if it were a check that I signed. I agree to pay any service charge that Anthem may bill me because the debit/charge was not successful. I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to reset the automatic monthly payments.

Please choose how you want to pay your monthly payments for all of your plans. Put a check in the box for either Option 1, Option 2 or Option 3.

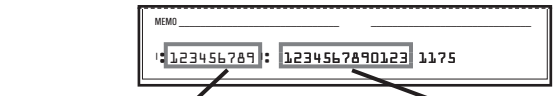
☐ Option 1: Have your first and future monthly payments automatically deducted from your bank account.

All of your monthly payments will be taken out of the bank account you check below.

Checking account: ☐ Business ☐ Personal
Savings account: ☐ Business ☐ Personal

Enter the requested debit date from your bank account ____ (1st to 6th of each month). If no date is requested your monthly payments will be debited on the first of each month.

Write the routing and account numbers that are on your check here: →



9-digit bank routing number	Bank account number

I agree that Anthem can automatically debit the **bank account** above each month. I understand monthly payments will be made on the day I've indicated. I agree that Anthem can debit my account until I let them know that I no longer want them to do this by giving them a 30-day advance written notice. I agree that should my bank not allow Anthem to debit my account for any reason, I will be removed from automatic monthly payments and will be billed by mail.

Authorized signature (as it appears on bank's records)	Printed bank account holder's name (as it appears on account)	Date (MM/DD/YY)
X		

☐ Option 2: Have your first and future monthly payments automatically charged to your credit/debit card.

Complete the information below.

Enter the requested charge date for your credit/debit card ____ (1st to 6th of each month).

I agree that Anthem can automatically charge my **credit/debit card** each month. I understand monthly payments will be made on the day I've indicated. I agree that Anthem can charge my account until I let them know that I no longer want them to do this by giving them a 30-day advance written notice. I agree that should any Anthem credit/debit card transaction not be honored, I will automatically be removed from automatic monthly payments and will be billed by mail.

Anthem accepts ☐ **Visa** **or** ☐ **MasterCard** **(Note to applicant: Please check one.)**

Card number	Expiration date ____ (MM/YY)	
Billing address for this credit/debit card	City	ZIP code

Authorized signature (as it appears on card)	Printed card holder's name (as it appears on card)	Date (MM/DD/YY)
X		

See page two for Option 3: Send us your first monthly payment now and receive a bill each month for your future monthly payments.

Payment Methods for Individual Applications

Anthem BlueCross BlueShield

Applicant/Member name	Primary applicant's Social Security number

☐ **Option 3: Send us your first monthly payment now and receive a bill each month for your future monthly payments.**

Choose one of the ways below that you would like to pay only your first monthly payment.

☐ Check (enclose your paper check with application) ☐ Electronic check (fill out section A below) ☐ Credit/Debit card (fill out section B below)

A. Electronic check: Instead of sending us a paper check, you can use an electronic check that allows Anthem to take the money right from your bank account to make your first payment on the day that your coverage is approved. You will not get the check back from your bank. (We will not keep this information on file or use it for any future payments.) Please fill out this information.

Printed account holder name	Routing number	Account number	Amount of first payment
			$

B. Credit/Debit card: I allow Anthem to charge the credit or debit card I listed below one time for my first monthly payment. This payment will cover the first monthly payment for all of the plans I have with Anthem.

Anthem accepts ☐ Visa or ☐ MasterCard (Note to applicant: Please check one.)

Card number	Expiration date (MM/YY)

Billing address for this credit/debit card	City	ZIP code

I agree that Anthem can debit/charge the bank account/card listed above **to make my first monthly payment only.**

I agree that Anthem will not have to pay any fees that my bank may charge because my electronic check or credit/debit card was rejected even if I can no longer continue coverage. I understand that **this is a one-time payment and that I am responsible for making sure Anthem receives my future monthly payments after this first payment.**

Authorized signature (as it appears on bank account/card)	Printed bank account/card holder's name (as it appears on account/card)	Date (MM/DD/YY)
X		

Get help in your language

Language Assistance Services

Anthem BlueCross BlueShield

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-886-6152). (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 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 (855-886-6152). (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 (855-886-6152). (TDD/TTY: 711)

Burmese
ဤစာရွက်စာတမ်းကို နားလည် သဘောပေါက်နိုင်ရန် အခြားဘာသာစကား တစ်မျိုးမျိုးဖြင့် သင်လိုအပ်ပါက အခကြေးငွေ ထပ်မံပေးအပ်စရာ မလိုပဲ အဖွဲ့ဝင်အတွက် ဝန်ဆောင်မှုများ ဌာန ဖုန်းနံပါတ် (855-886-6152) သို့ ခေါ်ဆိုကာ တောင်းခံနိုင်ပါသည်။
(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(855-886-6152)請求免費協助。(TTY/TDD: 711)

Dutch
Als u hulp nodig heeft om dit document te begrijpen in een andere taal, mag u daar zonder aanvullende kosten om vragen door te bellen met het ledenservicenummer (855-886-6152). (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 : 855-886-6152. (TTY/TDD: 711)

German
Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (855-886-6152). (TTY/TDD: 711)

Hindi
अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-886-6152) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

Japanese
この書面を他の言語で理解するための支援が必要な場合には、メンバーサービス番号（855-886-6152）に電話して支援を求めることができます。追加費用はかかりません。(TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-886-6152)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Pennsylvania Dutch
Wann du Helfe brauchscht um selle Document zu verschtehe in en annere Schprooch, du kannscht fer sell frooge um nix zu bezaahle. Ruff Member Services Nummer (855-886-6152) aa. (TTY/TDD: 711)

Punjabi
ਜੇ ਤੁਹਾਨੂੰ ਕਿਸੇ ਬਦਲਵੀਂ ਭਾਸ਼ਾ ਵਿੱਚ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਸਮਝਣ ਲਈ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ ਤੁਸੀਂ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ (855-886-6152) ਤੇ ਕਾਲ ਕਰਕੇ ਕਿਸੇ ਵਾਧੂ ਲਾਗਤ ਦੇ ਬਿਨਾਂ ਇਸ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। (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 (855-886-6152). (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 (855-886-6152). (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 (855-886-6152). (TTY/TDD: 711)

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.