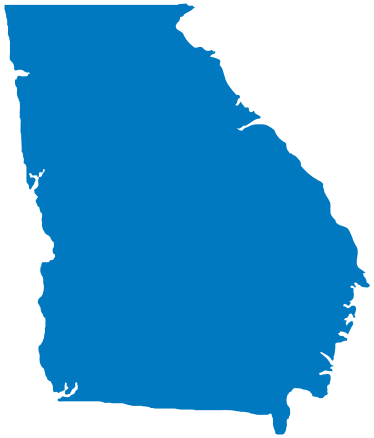
Open enrollment period runs
November 1, 2018 - December 15, 2018

Anthem

How to choose and use your health plan

Get the answers you need with this helpful guide



Georgia

2019 Plan Year

Individual and Family

Bronze, Silver, Gold and Catastrophic plans

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What you need to know to choose a plan that's right for you.

Your options for coverage

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

Dental/vision: With our health plans, you'll get pediatric essential health benefits for dental and vision. For extra coverage, Anthem Blue Cross and Blue Shield offers stand-alone dental and vision insurance for you and your whole family, with great care from leading doctors. Whether it's dental or vision you're looking for, we've got a plan for you.

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

Pharmacy: Pharmacy is the most widely used benefit—4X more than medical—and often the first benefit members access.[1] Getting the most out of your pharmacy benefits can help keep you healthy and save you money.

- **Your covered medications:** To see if your drug is covered, go to anthem.com/pharmacyinformation and choose the link, **Individual Select Drug List**.
- **Retail Pharmacies:** Your pharmacy benefit includes nearly 70,000 retail pharmacies nationwide. To see if your preferred pharmacy is in the plan's network, visit anthem.com/pharmacyinformation/rxnetworks.html.
- **Home Delivery:** Get your medicine delivered right to your door. People who use home delivery pharmacy are more likely to follow their drug treatment plan and have better health outcomes.

To learn more, call your representative.

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

Our retail and home delivery networks are owned and operated by our pharmacy benefit manager, Express Scripts.

1 Retail Prescription Drugs Filled at Pharmacies (Annual per Capita) (accessed 2/16/2017): kff.org; Ambulatory Care Use and Physician office visits, US Centers for Disease Control and Prevention (accessed 2/16/2017), https://www.cdc.gov/nchs/fastats/physician-visits.htm; https://www.cdc.gov/nchs/fastats/drug-use-therapeutic.htm; and http://www.statista.com/chart/2689/americans-dont-like-visiting-the-doctor (accessed June 17, 2015).

Answers to your questions

Why choose Anthem Blue Cross and Blue Shield?

When you choose an individual or family insurance plan with Anthem Blue Cross and Blue Shield, you'll have access to leading doctors and hospitals. It's important to us that you see the doctor you want and get the care you need.

You'll see the difference with Anthem Blue Cross and Blue Shield. You can select great doctors, care centers and hospitals from our network of providers. You can also have a private video visit with a doctor or therapist on your smartphone, tablet or computer. It's one of the best ways for us to help support your health and the health of your family.

Access to preventive care

At Anthem Blue Cross and Blue Shield, we believe that prevention is the best medicine. Preventive care is offered for as low as $0 with no copay and no deductible to meet when received from doctors in your plan.

With us, you can also count on:

- Dedicated customer service.
- One source for all your benefits, including dental, vision and term life.
- A simple enrollment process.
- Resources to support your health care goals.

Why do I need coverage?

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

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

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

1. **It's worth the price.** Have you ever thought about what the cost would be to have a major surgery without health insurance? Now picture adding that in with your mortgage/rent and monthly expenses. That's a case where monthly payments for coverage are small compared to footing the bill for a major unexpected cost.
2. **It helps you stay on top of checkups.** When you have coverage, you'll be much more likely to use it to get your yearly checkups and tests that can catch issues early. Plans even include preventive care at no extra cost when you use doctors in your plan (network doctors).
3. **It's an investment in you.** You insure your home and cars, so why would you put yourself at the bottom of the list? Think about how much it would cost to fix you if something serious were to happen.

Answers to your questions

What coverage do I need?

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

- **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?
- **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, lower monthly payment, Catastrophic plan. Catastrophic plans can help protect you from worst-case scenarios like serious accidents or illnesses.

Plan choices

Metal Levels

- **Bronze:** You'll have lower monthly payments while being covered for check ups and preventive care. You could pay more out of pocket if you need more care, but if you don't expect to go to the doctor very much this year, Bronze may be a good bet. These health plans can be great for people who are younger with no dependents.
- **Silver:** You'll get health coverage that covers all the basics and more. You'll also get preventive care for $0 with no copay and no deductible from network doctors. Silver plans on the Health Insurance Marketplace offer the greatest assistance for both tax credits and cost sharing subsidies if you qualify.

NEW! Enhanced Virtual Access Plans
Online Plus:

- Select bronze and silver plans offer unlimited, $5 online PCP office visit copays. Just look for ***Online Plus*** in the plan name.

Can I afford it?

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

You could be eligible for a subsidy, also called an advanced premium tax credit, to lower your monthly payment. You may also qualify for a plan where you'll pay less for your out-of-pocket costs.

Other ways to help save money:

Check if your favorite doctor, hospital or other health care provider is in your plan. That way you can make sure you get your care at the lower or negotiated network rate.

You can also save money by only using the emergency room (ER) for emergencies. Head straight to the ER or call 911 for serious health issues. Otherwise, save yourself money and time by visiting your primary care doctor, an urgent care center, or LiveHealth Online for minor medical issues.

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.

With a qualified high-deductible plan, you can set up the HSA through a bank and fund it with your post tax dollars. Before selecting an HSA plan, check with your tax advisor to see if an HSA plan is right for you.

Answers to your questions

How do I find a doctor or hospital?

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

1. Go to **anthem.com**.
2. Choose **Individual & Family** at the top of your screen. Then under **Care** select **Find a Doctor**.
3. Scroll past Search as a Member to **Search as Guest**.
4. Choose **Search by Selecting a Plan or Network** and complete the form.

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

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

What should I know about my network?

- **Health maintenance organization (HMO):** With our **Pathway Guided Access** plans, you have to choose a primary care doctor (PCP) to manage your health care needs — including getting referrals to see other network Once you're a member, log in to **anthem.com** to register and select a PCP or we'll select one for you. This can be changed at any time. Your PCP selection will be listed on your member ID card. If you don't visit the listed PCP, your claims will be denied. ***Pathway Guided Access plans are only available in the following counties: Cherokee, Cobb, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry and Richmond counties.*** Unlike our **Pathway Guided Access** plans, **Pathway** plans don't require a primary care doctor selection or a referral from a primary care doctor to see other network doctors. Having a primary care doctor is a good idea for things like checkups and any ongoing health issues. **These plans are available in Atkinson, Baldwin, Banks, Bartow, Berrien, Brooks, Burke, Carroll, Charlton, Chattooga, Clinch, Colquitt, Columbia, Cook, Coweta, Crawford, Dawson, Decatur, Early, Echols, Emanuel, Fannin, Floyd, Franklin, Gilmer, Glascock, Grady, Habersham, Hall, Hancock, Haralson, Hart, Heard, Jasper, Jefferson, Jenkins, Johnson, Lamar, Lanier, Laurens, Lincoln, Lowndes, Lumpkin, McDuffie, Morgan, Oglethorpe, Pickens, Pike, Polk, Rabun, Seminole, Stephens, Taliaferro, Thonas, Tift, Towns, Turner, Union, Upson, Ware, Warren, Washington, White, Wilkes and Wilkinson counties.**

  Important: Available plans will vary based on the county you reside in. Please use the guide on page 19 to make sure your selected plan is available in your county.

  HMOs don't offer non-network benefits, except for medically necessary emergency and urgent care or when a service is preapproved. If you see a doctor not in the plan for any other reason, you'll pay 100% out of pocket. These out-of-pocket expenses don't count toward the plan's deductible or out-of-pocket limit.

Anthem Blue Cross and Blue Shield advantages

Making informed health care decisions for you and your family is simple with our website, mobile app and helpful tools, like Estimate Your Cost.

No matter which plan you choose, you can register at anthem.com or on the Anthem Anywhere mobile app to get personalized information about your health plan.

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

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

With our Anthem Anywhere mobile app, you can:

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

LiveHealth® ONLINE

You can also take advantage of resources like LiveHealth Online:

Talk to a doctor whenever, wherever with LiveHealth Online	LiveHealth Online Psychology offers virtual counseling
Easy: Connect to a doctor 24 hours a day, from a computer, tablet, or smartphone. **Face-to-face**: Chat by two-way video for common health issues. **Save:** On average members save up to $201 for care, compared to ER, urgent care, or other health facilities.*	**Convenient:** Sessions go from 7 a.m. to 11 p.m., coast-to-coast. **Quick access:** Schedule a visit and be seen within four days, or on demand. **Similar cost:** Cost-share is the same as it is for in-office Mental Health/Substance Use therapy benefits.

*Results based on internal LiveHealth Online study during 2014 and first quarter, 2015.

Anthem Blue Cross and Blue Shield advantages

Plans include other features to help you and your family stay healthy at no additional cost.

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

Peace of mind when you travel.

Travel a lot? Don't worry. You're covered.

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

Plan benefit chart - HMO

The benefit information shown here is for network services. **Pathway Guided Access** plans don't include coverage for non-network benefits, except for medically necessary emergency and urgent care.
Important: Not all plans are available in all areas. Please use the guide on page 19 to make sure your selected plan is available in your county.

	Anthem Bronze Pathway Guided Access HMO 4600 Online Plus (37VN)	**Anthem Bronze Pathway Guided Access HMO 5200 (37T3)**	**Anthem Bronze Pathway Guided Access HMO 5500 (37T6)**
Network name	Pathway Guided Access	Pathway Guided Access	Pathway Guided Access
Plan includes non-network coverage?	No	No	No
Individual deductible	$4,600	$5,200	$5,500
Individual out-of-pocket limit	$7,900	$7,900	$7,900
Coinsurance (percentage may vary for some covered services)	30%	20%	40%
Office visit: primary care physician (PCP)[1,2] (Other office services may be subject to deductible and plan coinsurance)	$40 copay	$35 copay per visit for the first 2 visits, then deductible and 20% coinsurance	$50 copay per visit for the first 2 visits, then deductible and 40% coinsurance
Office visit: specialist[2] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 30% coinsurance	$70 copay per visit for the first 2 visits, then deductible and 20% coinsurance	$75 copay per visit for the first 2 visits, then deductible and 40% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $500 copay and 50% coinsurance	Deductible, then $400 copay and 50% coinsurance	Deductible, then $400 copay and 50% coinsurance
Urgent care	Deductible, then $50 copay and 30% coinsurance	Deductible, then $50 copay and 20% coinsurance	Deductible, then $50 copay and 40% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then $500 copay and 30% coinsurance	Deductible, then $500 copay and 20% coinsurance	Deductible, then $500 copay and 40% 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 $1,000 copay and 50% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]**: Level 1 / Level 2**	$20 copay / $30 copay	20% coinsurance / 30% coinsurance	40% coinsurance / 50% coinsurance
Retail pharmacy tier 2[4]**: Level 1 / Level 2**	$80 copay / $90 copay	20% coinsurance / 30% coinsurance	40% coinsurance / 50% coinsurance
Retail pharmacy tier 3[4]**: 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 20% coinsurance	Deductible, then 40% coinsurance
Speech therapy (limits apply)	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance

1 **LiveHealth Online** PCP web visits have the same PCP office visit cost share listed in the chart, except for Online Plus plans. Available on select bronze and silver plans, Online Plus offers unlimited, $5 online PCP office visit copays.
2 For plans with **PCP** and **Specialist** office visit limits, the visit limits are combined, not separate. PCP selection and referrals to most specialists are required for our **Pathway Guided Access** plans. See page 6 for more detail.
3 The network family deductible is 2 x the individual amount.
4 **Home delivery pharmacy** cost shares are 2.5 x the retail copay for Tier 1 drugs and 3 x the retail copay for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays.

Plan benefit chart - HMO

The benefit information shown here is for network services. **Pathway Guided Access** plans don't include coverage for non-network benefits, except for medically necessary emergency and urgent care.
Important: Not all plans are available in all areas. Please use the guide on page 19 to make sure your selected plan is available in your county.

	Anthem Bronze Pathway Guided Access HMO 0% for HSA (37T0)	**Anthem Bronze Pathway Guided Access HMO 6750 (37TC)**	**Anthem Silver Pathway Guided Access HMO 2000 (37TT)**
Network name	Pathway Guided Access	Pathway Guided Access	Pathway Guided Access
Plan includes non-network coverage?	No	No	No
Individual deductible	$6,700	$6,750	$2,000
Individual out-of-pocket limit	$6,700	$7,900	$7,900
Coinsurance (percentage may vary for some covered services)	0%	40%	25%
Office visit: primary care physician (PCP)[1,2] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	$35 copay
Office visit: specialist[2] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	$70 copay
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then 25% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 0% coinsurance	Deductible, then $500 copay and 50% coinsurance	Deductible, then $300 copay and 50% coinsurance
Urgent care	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then $50 copay and 25% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 0% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then $500 copay and 25% 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 40% coinsurance	Deductible, then 25% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]**: Level 1 / Level 2**	0% coinsurance / 0% coinsurance	25% coinsurance / 35% coinsurance	25% coinsurance / 35% coinsurance
Retail pharmacy tier 2[4]**: Level 1 / Level 2**	0% coinsurance / 0% coinsurance	35% coinsurance / 45% coinsurance	25% coinsurance / 35% coinsurance
Retail pharmacy tier 3[4]**: Level 1 / Level 2**	0% coinsurance / 0% coinsurance	45% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	0% coinsurance / 0% coinsurance	45% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then 25% coinsurance
Speech therapy (limits apply)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then 25% coinsurance

1 **LiveHealth Online** PCP web visits have the same PCP office visit cost share listed in the chart, except for Online Plus plans. Available on select bronze and silver plans, Online Plus offers unlimited, $5 online PCP office visit copays.
2 For plans with **PCP** and **Specialist** office visit limits, the visit limits are combined, not separate. PCP selection and referrals to most specialists are required for our **Pathway Guided Access** plans. See page 6 for more detail.
3 The network family deductible is 2 x the individual amount.
4 **Home delivery pharmacy** cost shares are 2.5 x the retail copay for Tier 1 drugs and 3 x the retail copay for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays.

Plan benefit chart - HMO

The benefit information shown here is for network services. **Pathway Guided Access** plans don't include coverage for non-network benefits, except for medically necessary emergency and urgent care.
Important: Not all plans are available in all areas. Please use the guide on page 19 to make sure your selected plan is available in your county.

	Anthem Silver Pathway Guided Access HMO 2100 Online Plus (37VX)	**Anthem Silver Pathway Guided Access HMO 3000 (37UH)**	**Anthem Silver Pathway Guided Access HMO 4950 (37UV)**
Network name	Pathway Guided Access	Pathway Guided Access	Pathway Guided Access
Plan includes non-network coverage?	No	No	No
Individual deductible	$2,100	$3,000	$4,950
Individual out-of-pocket limit	$7,900	$7,900	$6,500
Coinsurance (percentage may vary for some covered services)	20%	10%	35%
Office visit: primary care physician (PCP)[1,2] (Other office services may be subject to deductible and plan coinsurance)	$25 copay	$40 copay per visit for the first 3 visits, then deductible and 10% coinsurance	$35 copay
Office visit: specialist[2] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 20% coinsurance	$75 copay per visit for the first 3 visits, then deductible and 10% coinsurance	Deductible, then 35% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 35% 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 $500 copay and 50% coinsurance
Urgent care	Deductible, then $50 copay and 20% coinsurance	Deductible, then $50 copay and 10% coinsurance	Deductible, then $50 copay and 35% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then $500 copay and 20% coinsurance	Deductible, then $500 copay and 10% coinsurance	Deductible, then $500 copay and 35% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 20% 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 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 35% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]**: Level 1 / Level 2**	$20 copay / $30 copay	$10 copay / $20 copay	$10 copay / $15 copay
Retail pharmacy tier 2[4]**: Level 1 / Level 2**	$50 copay / $60 copay	$40 copay / $50 copay	$40 copay / $50 copay
Retail pharmacy tier 3[4]**: 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 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 35% coinsurance
Speech therapy (limits apply)	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 35% coinsurance

1 **LiveHealth Online** PCP web visits have the same PCP office visit cost share listed in the chart, except for Online Plus plans. Available on select bronze and silver plans, Online Plus offers unlimited, $5 online PCP office visit copays.
2 For plans with **PCP** and **Specialist** office visit limits, the visit limits are combined, not separate. PCP selection and referrals to most specialists are required for our **Pathway Guided Access** plans. See page 6 for more detail.
3 The network family deductible is 2 x the individual amount.
4 **Home delivery pharmacy** cost shares are 2.5 x the retail copay for Tier 1 drugs and 3 x the retail copay for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays.

Plan benefit chart - HMO

The benefit information shown here is for network services. **Pathway Guided Access** plans don't include coverage for non-network benefits, except for medically necessary emergency and urgent care.
Important: Not all plans are available in all areas. Please use the guide on page 19 to make sure your selected plan is available in your county.

	Anthem Silver Pathway Guided Access HMO 5300 (37UB)	**Anthem Silver Pathway Guided Access HMO 6000 (37V7)**	**Anthem Silver Pathway Guided Access HMO 6000 30% (37W9)**
Network name	Pathway Guided Access	Pathway Guided Access	Pathway Guided Access
Plan includes non-network coverage?	No	No	No
Individual deductible	$5,300	$6,000	$6,000
Individual out-of-pocket limit	$7,900	$7,900	$7,900
Coinsurance (percentage may vary for some covered services)	25%	30%	30%
Office visit: primary care physician (PCP)[1,2] (Other office services may be subject to deductible and plan coinsurance)	$35 copay	$40 copay	$40 copay
Office visit: specialist[2] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 25% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $300 copay and 50% coinsurance	Deductible, then $500 copay and 50% coinsurance	Deductible, then $500 copay and 50% coinsurance
Urgent care	Deductible, then $50 copay	Deductible, then $50 copay	Deductible, then $50 copay
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then $500 copay and 25% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then $500 copay and 30% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 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 25% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]**: Level 1 / Level 2**	$10 copay / $20 copay	$10 copay / $20 copay	$10 copay / $20 copay
Retail pharmacy tier 2[4]**: Level 1 / Level 2**	$40 copay / $50 copay	$40 copay / $50 copay	$40 copay / $50 copay
Retail pharmacy tier 3[4]**: 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 25% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
Speech therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance

1 **LiveHealth Online** PCP web visits have the same PCP office visit cost share listed in the chart, except for Online Plus plans. Available on select bronze and silver plans, Online Plus offers unlimited, $5 online PCP office visit copays.
2 For plans with **PCP** and **Specialist** office visit limits, the visit limits are combined, not separate. PCP selection and referrals to most specialists are required for our **Pathway Guided Access** plans. See page 6 for more detail.
3 The network family deductible is 2 x the individual amount.
4 **Home delivery pharmacy** cost shares are 2.5 x the retail copay for Tier 1 drugs and 3 x the retail copay for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays.

Plan benefit chart - HMO

The benefit information shown here is for network services. **Pathway Guided Access** plans don't include coverage for non-network benefits, except for medically necessary emergency and urgent care.
Important: Not all plans are available in all areas. Please use the guide on page 19 to make sure your selected plan is available in your county.

	Anthem Catastrophic Pathway Guided Access HMO 7900 (37SP)
Network name	Pathway Guided Access
Plan includes non-network coverage?	No
Individual deductible	$7,900
Individual out-of-pocket limit	$7,900
Coinsurance (percentage may vary for some covered services)	0%
Office visit: primary care physician (PCP)[1,2] (Other office services may be subject to deductible and plan coinsurance)	$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance
Office visit: specialist[2] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 0% coinsurance
Urgent care	Deductible, then 0% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]**: Level 1 / Level 2**	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2[4]**: Level 1 / Level 2**	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3[4]**: Level 1 / Level 2**	0% coinsurance / 0% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 0% coinsurance
Speech therapy (limits apply)	Deductible, then 0% coinsurance

1 **LiveHealth Online** PCP web visits have the same PCP office visit cost share listed in the chart, except for Online Plus plans. Available on select bronze and silver plans, Online Plus offers unlimited, $5 online PCP office visit copays.
2 For plans with **PCP** and **Specialist** office visit limits, the visit limits are combined, not separate. PCP selection and referrals to most specialists are required for our **Pathway Guided Access** plans. See page 6 for more detail.
3 The network family deductible is 2 x the individual amount.
4 **Home delivery pharmacy** cost shares are 2.5 x the retail copay for Tier 1 drugs and 3 x the retail copay for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays.

Plan benefit chart - HMO

The benefit information shown here is for network services. **Pathway** plans don't include coverage for non-network benefits, except for medically necessary emergency and urgent care.
Important: Not all plans are available in all areas. Please use the guide on page 19 to make sure your selected plan is available in your county.

	Anthem Bronze Pathway HMO 4600 Online Plus (37VK)	Anthem Bronze Pathway HMO 5200 (37SU)	Anthem Bronze Pathway HMO 5500 (37SX)
Network name	Pathway	Pathway	Pathway
Plan includes non-network coverage?	No	No	No
Individual deductible	$4,600	$5,200	$5,500
Individual out-of-pocket limit	$7,900	$7,900	$7,900
Coinsurance (percentage may vary for some covered services)	30%	20%	40%
Office visit: primary care physician (PCP)[1,2] (Other office services may be subject to deductible and plan coinsurance)	$40 copay	$35 copay per visit for the first 2 visits, then deductible and 20% coinsurance	$50 copay per visit for the first 2 visits, then deductible and 40% coinsurance
Office visit: specialist[2] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 30% coinsurance	$70 copay per visit for the first 2 visits, then deductible and 20% coinsurance	$75 copay per visit for the first 2 visits, then deductible and 40% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $500 copay and 50% coinsurance	Deductible, then $400 copay and 50% coinsurance	Deductible, then $400 copay and 50% coinsurance
Urgent care	Deductible, then $50 copay and 30% coinsurance	Deductible, then $50 copay and 20% coinsurance	Deductible, then $50 copay and 40% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then $500 copay and 30% coinsurance	Deductible, then $500 copay and 20% coinsurance	Deductible, then $500 copay and 40% 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 $1,000 copay and 50% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]**: Level 1 / Level 2**	$20 copay / $30 copay	20% coinsurance / 30% coinsurance	40% coinsurance / 50% coinsurance
Retail pharmacy tier 2[4]**: Level 1 / Level 2**	$80 copay / $90 copay	20% coinsurance / 30% coinsurance	40% coinsurance / 50% coinsurance
Retail pharmacy tier 3[4]**: 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 20% coinsurance	Deductible, then 40% coinsurance
Speech therapy (limits apply)	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance

1 **LiveHealth Online** PCP web visits have the same PCP office visit cost share listed in the chart, except for Online Plus plans. Available on select bronze and silver plans, Online Plus offers unlimited, $5 online PCP office visit copays.
2 For plans with **PCP** and **Specialist** office visit limits, the visit limits are combined, not separate. PCP selection and referrals to most specialists are required for our **Pathway Guided Access** plans. See page 6 for more detail.
3 The network family deductible is 2 x the individual amount.
4 **Home delivery pharmacy** cost shares are 2.5 x the retail copay for Tier 1 drugs and 3 x the retail copay for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays.

Plan benefit chart - HMO

The benefit information shown here is for network services. **Pathway** plans don't include coverage for non-network benefits, except for medically necessary emergency and urgent care.
Important: Not all plans are available in all areas. Please use the guide on page 19 to make sure your selected plan is available in your county.

	Anthem Bronze Pathway HMO 0% for HSA (37SR)	**Anthem Bronze Pathway HMO 6750 (37T9)**	**Anthem Silver Pathway HMO 2000 (37TM)**
Network name	Pathway	Pathway	Pathway
Plan includes non-network coverage?	No	No	No
Individual deductible	$6,700	$6,750	$2,000
Individual out-of-pocket limit	$6,700	$7,900	$7,900
Coinsurance (percentage may vary for some covered services)	0%	40%	25%
Office visit: primary care physician (PCP)[1,2] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	$35 copay
Office visit: specialist[2] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	$70 copay
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then 25% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 0% coinsurance	Deductible, then $500 copay and 50% coinsurance	Deductible, then $300 copay and 50% coinsurance
Urgent care	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then $50 copay and 25% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 0% coinsurance	Deductible, then $500 copay and 40% coinsurance	Deductible, then $500 copay and 25% 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 40% coinsurance	Deductible, then 25% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]**: Level 1 / Level 2**	0% coinsurance / 0% coinsurance	25% coinsurance / 35% coinsurance	25% coinsurance / 35% coinsurance
Retail pharmacy tier 2[4]**: Level 1 / Level 2**	0% coinsurance / 0% coinsurance	35% coinsurance / 45% coinsurance	25% coinsurance / 35% coinsurance
Retail pharmacy tier 3[4]**: Level 1 / Level 2**	0% coinsurance / 0% coinsurance	45% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	0% coinsurance / 0% coinsurance	45% coinsurance / 50% coinsurance	40% coinsurance / 50% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then 25% coinsurance
Speech therapy (limits apply)	Deductible, then 0% coinsurance	Deductible, then 40% coinsurance	Deductible, then 25% coinsurance

1 **LiveHealth Online** PCP web visits have the same PCP office visit cost share listed in the chart, except for Online Plus plans. Available on select bronze and silver plans, Online Plus offers unlimited, $5 online PCP office visit copays.
2 For plans with **PCP** and **Specialist** office visit limits, the visit limits are combined, not separate. PCP selection and referrals to most specialists are required for our **Pathway Guided Access** plans. See page 6 for more detail.
3 The network family deductible is 2 x the individual amount.
4 **Home delivery pharmacy** cost shares are 2.5 x the retail copay for Tier 1 drugs and 3 x the retail copay for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays.

Plan benefit chart - HMO

The benefit information shown here is for network services. **Pathway** plans don't include coverage for non-network benefits, except for medically necessary emergency and urgent care.
Important: Not all plans are available in all areas. Please use the guide on page 19 to make sure your selected plan is available in your county.

	Anthem Silver Pathway HMO 2100 Online Plus (37VR)	**Anthem Silver Pathway HMO 3000 (37TF)**	**Anthem Silver Pathway HMO 4950 (37UP)**
Network name	Pathway	Pathway	Pathway
Plan includes non-network coverage?	No	No	No
Individual deductible	$2,100	$3,000	$4,950
Individual out-of-pocket limit	$7,900	$7,900	$6,500
Coinsurance (percentage may vary for some covered services)	20%	10%	35%
Office visit: primary care physician (PCP)[1,2] (Other office services may be subject to deductible and plan coinsurance)	$25 copay	$40 copay per visit for the first 3 visits, then deductible and 10% coinsurance	$35 copay
Office visit: specialist[2] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 20% coinsurance	$75 copay per visit for the first 3 visits, then deductible and 10% coinsurance	Deductible, then 35% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 35% 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 $500 copay and 50% coinsurance
Urgent care	Deductible, then $50 copay and 20% coinsurance	Deductible, then $50 copay and 10% coinsurance	Deductible, then $50 copay and 35% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then $500 copay and 20% coinsurance	Deductible, then $500 copay and 10% coinsurance	Deductible, then $500 copay and 35% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 20% 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 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 35% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]**: Level 1 / Level 2**	$20 copay / $30 copay	$10 copay / $20 copay	$10 copay / $15 copay
Retail pharmacy tier 2[4]**: Level 1 / Level 2**	$50 copay / $60 copay	$40 copay / $50 copay	$40 copay / $50 copay
Retail pharmacy tier 3[4]**: 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 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 35% coinsurance
Speech therapy (limits apply)	Deductible, then 20% coinsurance	Deductible, then 10% coinsurance	Deductible, then 35% coinsurance

1 **LiveHealth Online** PCP web visits have the same PCP office visit cost share listed in the chart, except for Online Plus plans. Available on select bronze and silver plans, Online Plus offers unlimited, $5 online PCP office visit copays.
2 For plans with **PCP** and **Specialist** office visit limits, the visit limits are combined, not separate. PCP selection and referrals to most specialists are required for our **Pathway Guided Access** plans. See page 6 for more detail.
3 The network family deductible is 2 x the individual amount.
4 **Home delivery pharmacy** cost shares are 2.5 x the retail copay for Tier 1 drugs and 3 x the retail copay for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays.

Plan benefit chart - HMO

The benefit information shown here is for network services. **Pathway** plans don't include coverage for non-network benefits, except for medically necessary emergency and urgent care.
Important: Not all plans are available in all areas. Please use the guide on page 19 to make sure your selected plan is available in your county.

	Anthem Silver Pathway HMO 5300 (37TZ)	**Anthem Silver Pathway HMO 6000 (37V1)**	**Anthem Silver Pathway HMO 6000 30% (37W3)**
Network name	Pathway	Pathway	Pathway
Plan includes non-network coverage?	No	No	No
Individual deductible	$5,300	$6,000	$6,000
Individual out-of-pocket limit	$7,900	$7,900	$7,900
Coinsurance (percentage may vary for some covered services)	25%	30%	30%
Office visit: primary care physician (PCP)[1,2] (Other office services may be subject to deductible and plan coinsurance)	$35 copay	$40 copay	$40 copay
Office visit: specialist[2] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 25% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then $300 copay and 50% coinsurance	Deductible, then $500 copay and 50% coinsurance	Deductible, then $500 copay and 50% coinsurance
Urgent care	Deductible, then $50 copay	Deductible, then $50 copay	Deductible, then $50 copay
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then $500 copay and 25% coinsurance	Deductible, then $500 copay and 30% coinsurance	Deductible, then $500 copay and 30% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 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 25% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Level 1 / Level 2 Pharmacy Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]**: Level 1 / Level 2**	$10 copay / $20 copay	$10 copay / $20 copay	$10 copay / $20 copay
Retail pharmacy tier 2[4]**: Level 1 / Level 2**	$40 copay / $50 copay	$40 copay / $50 copay	$40 copay / $50 copay
Retail pharmacy tier 3[4]**: 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 25% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
Speech therapy (limits apply)	Deductible, then 25% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance

1 **LiveHealth Online** PCP web visits have the same PCP office visit cost share listed in the chart, except for Online Plus plans. Available on select bronze and silver plans, Online Plus offers unlimited, $5 online PCP office visit copays.
2 For plans with **PCP** and **Specialist** office visit limits, the visit limits are combined, not separate. PCP selection and referrals to most specialists are required for our **Pathway Guided Access** plans. See page 6 for more detail.
3 The network family deductible is 2 x the individual amount.
4 **Home delivery pharmacy** cost shares are 2.5 x the retail copay for Tier 1 drugs and 3 x the retail copay for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays.

Plan benefit chart - HMO

The benefit information shown here is for network services. **Pathway** plans don't include coverage for non-network benefits, except for medically necessary emergency and urgent care.
Important: Not all plans are available in all areas. Please use the guide on page 19 to make sure your selected plan is available in your county.

	Anthem Catastrophic Pathway HMO 7900 (37SM)
Network name	Pathway
Plan includes non-network coverage?	No
Individual deductible	$7,900
Individual out-of-pocket limit	$7,900
Coinsurance (percentage may vary for some covered services)	0%
Office visit: primary care physician (PCP)[1,2] (Other office services may be subject to deductible and plan coinsurance)	$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance
Office visit: specialist[2] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Ex. X-ray, EKG)	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Ex. MRI, CT scan)	Deductible, then 0% coinsurance
Urgent care	Deductible, then 0% coinsurance
Emergency room care (Copay, if applicable, waived if admitted into the hospital from the emergency room.)	Deductible, then 0% coinsurance
Hospital: inpatient admission (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility (includes maternity, mental health / substance use)	Deductible, then 0% coinsurance
Pharmacy deductible[3] (for tiers with deductible, cost share applies after deductible)	Level 1 / Level 2 Pharmacy Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1[4]**: Level 1 / Level 2**	0% coinsurance / 0% coinsurance
Retail pharmacy tier 2[4]**: Level 1 / Level 2**	0% coinsurance / 0% coinsurance
Retail pharmacy tier 3[4]**: Level 1 / Level 2**	0% coinsurance / 0% coinsurance
Retail pharmacy tier 4: Level 1 / Level 2	0% coinsurance / 0% coinsurance
Physical and occupational therapy (limits apply)	Deductible, then 0% coinsurance
Speech therapy (limits apply)	Deductible, then 0% coinsurance

1 **LiveHealth Online** PCP web visits have the same PCP office visit cost share listed in the chart, except for Online Plus plans. Available on select bronze and silver plans, Online Plus offers unlimited, $5 online PCP office visit copays.
2 For plans with **PCP** and **Specialist** office visit limits, the visit limits are combined, not separate. PCP selection and referrals to most specialists are required for our **Pathway Guided Access** plans. See page 6 for more detail.
3 The network family deductible is 2 x the individual amount.
4 **Home delivery pharmacy** cost shares are 2.5 x the retail copay for Tier 1 drugs and 3 x the retail copay for Tier 2 and Tier 3 drugs when the plan has retail pharmacy copays.

Which plans are available in my area?

Not all of our plans are available in all areas. You can use this guide to make sure your selected plan is available in your county. Please select one medical plan by network and contract code below according to the county where you reside. You can find the plan's network name and contract code in the plan name on benefit charts (pages 9-18).
For example: Anthem Silver Pathway X HMO 6000 30% (37W4)

Pathway Guided Access:

These network plans are only available in the following counties: Cherokee, Cobb, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry counties				**These network plans are only available in the following counties: Richmond county**		
Anthem Bronze Pathway Guided Access	**Anthem Silver Pathway Guided Access**	**Anthem Catastrophic Pathway Guided Access**		**Anthem Bronze Pathway Guided Access**	**Anthem Silver Pathway Guided Access**	**Anthem Catastrophic Pathway Guided Access**
0% for HSA (37T0)	2000 (37TT)	7900 (37SP)		0% for HSA (37T0)	2100 Online Plus (37VX)	7900 (37SP)
4600 Online Plus (37VN)	2100 Online Plus (37VX)			4600 Online Plus (37VN)	6000 (37V7)	
5200 (37T3)	3000 (37UH)			5200 (37T3)		
5500 (37T6)	4950 (37UV)			5500 (37T6)		
6750 (37TC)	5300 (37UB)			6750 (37TC)		
	6000 30% (37W9)					

Pathway:

These network plans are only available in the following counties: Banks, Bartow, Chattooga, Coweta, Dawson, Fannin, Floyd, Franklin, Gilmer, Habersham, Hall, Hart, Lamar, Lumpkin, Pickens, Pike, Polk, Rabun, Stephens, Towns, Union, White counties.			**These network plans are only available in the following counties: Atkinson, Baldwin, Berrien, Brooks, Burke, Carroll, Charlton, Clinch, Colquitt, Columbia, Cook, Crawford, Decatur, Early, Echols, Emanuel, Glascock, Grady, Hancock, Haralson, Heard, Jasper, Jefferson, Jenkins, Johnson, Lanier, Laurens, Lincoln, Lowndes, McDuffie, Morgan, Oglethorpe, Seminole, Taliaferro, Thomas, Tift, Turner, Upson, Ware, Warren, Washington, Wilkes, Wilkinson counties**		
Anthem Bronze Pathway	**Anthem Silver Pathway**	**Anthem Catastrophic Pathway**	**Anthem Bronze Pathway**	**Anthem Silver Pathway**	**Anthem Catastrophic Pathway**
0% for HSA (37SR)	2000 (37TM)	7900 (37SM)	0% for HSA (37SR)	2100 Online Plus (37VR)	7900 (37SM)
4600 Online Plus (37VK)	2100 Online Plus (37VR)		4600 Online Plus (37VK)	6000 (37V1)	
5200 (37SU)	3000 (37TF)		5200 (37SU)		
5500 (37SX)	4950 (37UP)		5500 (37SX)		
6750 (37T9)	5300 (37TZ)		6750 (37T9)		
	6000 30% (37W3)				

Understanding insurance terms

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

Here’s what they mean:

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

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

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

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

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

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

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

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

Ready to enroll? Let's get started.

Help is close at hand:

Call your broker to enroll or learn more about our health care plans. Take a look at the **application** included with this brochure.

Visit our website at anthem.com and apply online.

You can buy health care plans once a year through an open enrollment period. This year, the open enrollment period runs from **November 1, 2018 - December 15, 2018**. Be sure to enroll by December 15, 2018, to start coverage effective January 1, 2019.

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

We want you to be satisfied

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

Summary of benefits and services

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the *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 broker


Go to anthem.com.

To access a ***Summary of Benefits and Coverage (SBC)***, please visit **sbc.anthem.com** and select **NEXT** for Summaries in English or Spanish. Other languages can also be selected.

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 Affordable Care Act (ACA), the following plan changes may occur annually on January 1:

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

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

Important legal information

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

Eligibility

You can apply for coverage for yourself or with your family. You must be a United States citizen or national; a resident of the State of Georgia 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 also 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 benefit year. The actual effective date is determined by the date Anthem receives a complete application with the applicable premium payment.

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

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

Utilization review

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

Reviewing where services are provided

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

Examples include, but are not limited to:

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

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

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

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

- An inpatient hospital visit;
- An outpatient procedure;

Important legal information

- 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 network provider is responsible for seeking prior authorization for you. If you choose to receive treatment from a non-network provider, you will be responsible for seeking prior authorization. Plus, costs are usually lower with a network doctor. If you choose a non-network provider, be sure to call us to get prior authorization. Non-network providers may not do that for you. It is important to understand that not all plans offer out of network coverage, with the exception of emergency or urgent care. Please review the Contract in order to determine your benefits. 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 primary care doctors are the key to providing and coordinating your health care services. Your benefits are maximized when you allow your primary care doctor to manage your care and help select other network providers and specialists as needed.

Services you obtain from any provider other than a PCP, SCP or another network provider are considered a non-network service and you will be responsible for 100% of the cost. Except for emergency care or urgent care services received at an urgent care center or ambulance services related to an emergency for transportation to a hospital, or as an authorized service.

Non-network providers

With our HMO plans, services will not be covered services if rendered by non-network providers unless:

- The services are for medically necessary emergency care, urgent care or ambulance services related to an emergency for transportation to a hospital or urgent care services received at an urgent care center, as specified in the Contract; or
- The services are approved in advance by Anthem.

Services which are not obtained from your network PCP, a referred network specialist or another network provider that are not an authorized service will be considered a non-network service. You'll pay the full cost of services received from non-network providers, except for medically necessary emergency and urgent care services received at an urgent care center or ambulance services related to an emergency for transportation to a hospital. In addition, certain services are not covered unless obtained from a network provider. See your Schedule of Cost Shares and Benefits.

Laws and rights that protect you

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

Limitations

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

Important legal information

- Chiropractic – 20 visits for manipulation per member per year
- Habilitation services:
  - Physical and occupational therapy – 20 combined visits per member per year
  - Speech therapy – 20 visits per member per year
  - Respiratory therapy – 20 visits per member per year
  - Cardiac therapy – 20 visits per member per year
- Home health care – 120 visits per year
- Rehabilitation services:
  - Physical and occupational therapy – 20 combined visits per member per year
  - Speech therapy – 20 visits per member per year
  - Respiratory therapy – 20 visits per member per year
  - Cardiac therapy – 20 visits per member per year
- Skilled nursing facility – 60 days per year
- Transplants – per transplant
  - Transportation and lodging – limited to $10,000
  - Donor search – limited to $30,000

Exclusions

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

- Acupuncture
- Alternative or complementary medicine
- Artificial insemination, in vitro fertilization, other types of artificial or surgical means of conception including drugs administered in connection with these procedures
- Artificial and mechanical hearts
- Bariatric surgery
- Benefits covered by Medicare or a governmental program
- Breast reduction or augmentation
- Care provided by a member of your family
- Care received in an emergency room that is not emergency care, except as specified in the Contract
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services)
- Comfort and/or convenience items
- Compound drugs except as described in the Contract
- Cosmetic surgery and/or treatment that's primarily intended to improve your appearance
- Custodial care
- Dental, except as described in the Contract
- Educational services
- Experimental or investigative treatment
- Hearing aids for adults 19 and older
- In-vitro fertilization (IVF) as described in the Contract's exclusions
- Non-chemical addictions such as gambling, spending, religious
- Non-emergency care when traveling outside of Georgia or the U.S.
- Non-formulary prescriptions are not covered
- Nutritional and dietary supplements
- Over-the-counter drugs, devices or products
- Pharmacy, except as described in the Contract
- Routine foot care
- Sclerotherapy (a medical procedure used to eliminate varicose veins and spider veins)
- Services we determine aren't medically necessary
- Vision, except as described in the Contract
- Weight loss programs or treatment of obesity, except as mandated
- Workers' compensation

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

It's important we treat you fairly

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

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (1-855-837-8540). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number listed above.

Spanish

Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (1-855-837-8540). (TTY/TDD: 711)

Amharic

ይህንን ሰነድ ለመረዳት በአማራጭ ቋንቋ እርዳታ ማግኘት ከፈለጉ፣ የአባል አገልግለቶች ቁጥርን (1-855-837-8540) **በመደወል ያለምንም ክፍያ ማግኘት ይችላሉ።** (TTY/TDD: 711)

Arabic

إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة. (1-855-837-8540) دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (TTY/TDD: 711)

Chinese

如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(1-855-837-8540)請求免費協助。(TTY/TDD: 711)

Farsi

در صورتی که برای درک این سند به زبانی دیگر نیازمند کمک هستید، می‌توانید بدون هیچ هزینه اضافی این را درخواست کنید. برای این کار با مرکز خدمات اعضاء به شماره 1-855-837-8540 تماس بگیرید، (TTY/TDD: 711)

French

Si vous avez besoin d’aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 1-855-837-8540. (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 (1-855-837-8540). (TTY/TDD: 711)

Gujarati

વૈકલ્પિક ભાષામાં આ દસ્તાવેજો સમજવામાં તમને કોઈ મદદની જરૂર હોય તો તમે મેમ્બર સર્વિસ નંબર (1-855-837-8540). પર કોલ કરીને કોઈપણ વધારાના ખર્ચ વિના વિનંતી કરી શકો છો. (TTY/TDD: 711)

Haitian

Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (1-855-837-8540). (TTY/TDD: 711)

Hindi

अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (1-855-837-8540) 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（1-855-837-8540）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(1-855-837-8540)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Portuguese-Europe

Se necessitar de ajuda para compreender este documento noutro idioma, poderá solicitá-la gratuitamente ligando para o número dos Serviços para Membros (1-855-837-8540). (TTY/TDD: 711)

Get help in your language

Russian

Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (1-855-837-8540). (TTY/TDD: 711)

Vietnamese

Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (1-855-837-8540). (TTY/TDD: 711)

So that's how it all works.

Still have questions? Just ask. We're here to help.

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

05521GAMENABS 7/18

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®

03678MUMENABS Rev. 7/18

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 **1-866-686-4798** or **1-855-545-4168** (for TDD callers) Mon - Fri 8 a.m. to 11 p.m. (ET); Sat - Sun 9 a.m. to 6 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.**

Primary applicant name: _____

Welcome

Georgia 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) 206-0913. But if you've worked with an agent or broker, contact them first.

Did you know?

Anthem Life Insurance Company now offers low cost term life insurance coverage. Apply online at anthem.com or call us for additional information at 1 (877) 206-0913. Term Life Insurance underwritten by Anthem Life Insurance Company.

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**
   Your coverage will start based on when we receive your complete application; however, the earliest your coverage can start is January 1st.
2. **Due to a qualifying event**
   When you're done with this form, fill out **Appendix A: Special Enrollment,** which includes information about when coverage starts.
3. **For new dental and vision**
   - For new dental and vision coverage, you can apply any time during the year.
   - If you apply with medical, your effective dates will match.
   - If you apply without medical, your coverage will start based on when we receive your complete application. If we get it between the 1st and last day of the month, coverage is effective the 1st day of the following month.

Tips when filling out this form

1. Answer all questions. Please print clearly using blue or black ink only.
2. Please submit all pages.
3. You can also apply online at anthem.com.
4. Refer to your Health Plan Guide for plan and enrollment details. Don't have a copy? Ask your agent or contact us.
5. If you're enrolling in an HMO plan, you may need to choose a Primary Care Physician (PCP). View a list of doctors for your plan on anthem.com or call us. If you don't choose a PCP and it's required for your plan, we'll pick one located close to you.

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 or money order until you've been enrolled. If you're already a member, we need your payment before the requested effective date for your change.
2. **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 may give it to our HSA banking partner.

Please indicate the reason you are submitting this application for medical:
☐ Open Enrollment
☐ Special Enrollment Period – must also complete Appendix A

Step 1: Who is applying?

☐ New coverage
☐ Change coverage
☐ Add dependent to existing coverage

Subscriber ID no. _____

Primary applicant

Last name (legal name)		**First name** (legal name)		**M.I.**	**Social Security Number** - -
Marital status ☐ Single ☐ Married ☐ Domestic Partner	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of GA** ☐ Yes ☐ No	**County** (for home address)	**Tobacco use**[1] ☐ Yes ☐ No
Home address (not a P.O. Box)				**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)		
PCP (Guided Access HMO Plans only)			**PCP ID**		**Current patient** ☐ Yes ☐ No

Coverage(s) selected ☐ Medical* ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse/Domestic Partner and/or dependent coverage eligibility.
All family members listed will be included in the medical product if the medical option is selected.

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 GA** ☐ Yes ☐ No		**Tobacco use**[1] ☐ Yes ☐ No
PCP (Guided Access HMO Plans only)			**PCP ID**		**Current patient** ☐ Yes ☐ No

Coverage(s) selected ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse/Domestic Partner and/or dependent coverage eligibility.
All family members listed will be included in the medical product if the medical option is selected.

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 GA** ☐ Yes ☐ No		**Tobacco use**[1] ☐ Yes ☐ No
PCP (Guided Access HMO Plans only)			**PCP ID**		**Current patient** ☐ Yes ☐ No

Coverage(s) selected ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse/Domestic Partner and/or dependent coverage eligibility.
All family members listed will be included in the medical product if the medical option is selected.

1 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).

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 GA** ☐ Yes ☐ No		**Tobacco use**[1] ☐ Yes ☐ No
PCP (Guided Access HMO Plans only)			**PCP ID**		**Current patient** ☐ Yes ☐ No
Coverage(s) selected ☐ Dental* ☐ Vision* *Primary applicant must be included for Spouse/Domestic Partner and/or dependent coverage eligibility. All family members listed will be included in the medical product if the medical option is selected.					

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 GA** ☐ Yes ☐ No		**Tobacco use**[1] ☐ Yes ☐ No
PCP (Guided Access HMO Plans only)			**PCP ID**		**Current patient** ☐ Yes ☐ No
Coverage(s) selected ☐ Dental* ☐ Vision* *Primary applicant must be included for Spouse/Domestic Partner and/or dependent coverage eligibility. All family members listed will be included in the medical product if the medical option is selected.					

1 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

The answers to these questions are needed to determine your eligibility.

Are any applicants enrolled in 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?**	

Step 2: What coverage would you like?

Medical Plans

Please select one medical plan from the below Pathway Guided Access HMO plans only if you reside in one of the following counties: Cherokee, Cobb, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, and Henry. *These plans require the selection of a PCP.

Anthem Bronze	Anthem Silver	Anthem Catastrophic
		Only available to applicants under age 30, unless otherwise qualified.
Pathway Guided Access HMO ☐ 0% for HSA (37T0)* ☐ 4600 Online Plus (37VN)* ☐ 5200 (37T3)* ☐ 5500 (37T6)* ☐ 6750 (37TC)*	**Pathway Guided Access HMO** ☐ 2000 (37TT)* ☐ 2100 Online Plus (37VX)* ☐ 3000 (37UH)* ☐ 4950 (37UV)* ☐ 5300 (37UB)* ☐ 6000/30% (37W9)*	**Pathway Guided Access HMO** ☐ 7900 (37SP)*

Please select one medical plan from the below Pathway Guided Access HMO plans only if you reside in one of the following counties: Richmond. *These plans require the selection of a PCP.

Anthem Bronze	Anthem Silver	Anthem Catastrophic
		Only available to applicants under age 30, unless otherwise qualified.
Pathway Guided Access HMO ☐ 0% for HSA (37T0)* ☐ 4600 Online Plus (37VN)* ☐ 5200 (37T3)* ☐ 5500 (37T6)* ☐ 6750 (37TC)*	**Pathway Guided Access HMO** ☐ 2100 Online Plus (37VX)* ☐ 6000 (37V7)*	**Pathway Guided Access HMO** ☐ 7900 (37SP)*

Please select one medical plan from the below Pathway HMO plans only if you reside in one of the following counties: Banks, Bartow, Chattooga, Coweta, Dawson, Fannin, Floyd, Franklin, Gilmer, Habersham, Hall, Hart, Lamar, Lumpkin, Pickens, Pike, Polk, Rabun, Stephens, Towns, Union, and White. Please be sure to select a PCP in Step 1.

Anthem Bronze	Anthem Silver	Anthem Catastrophic
		Only available to applicants under age 30, unless otherwise qualified.
Pathway HMO ☐ 0% for HSA (37SR)* ☐ 4600 Online Plus (37VK)* ☐ 5200 (37SU)* ☐ 5500 (37SX)* ☐ 6750 (37T9)*	**Pathway HMO** ☐ 2000 (37TM)* ☐ 2100 Online Plus (37VR)* ☐ 3000 (37TF)* ☐ 4950 (37UP)* ☐ 5300 (37TZ)* ☐ 6000/30% (37W3)*	**Pathway HMO** ☐ 7900 (37SM)*

Please select one medical plan from the below Pathway HMO plans only if you reside in one of the following counties: Atkinson, Baldwin , Berrien, Brooks, Burke, Carroll, Charlton, Clinch, Colquitt, Columbia, Cook, Crawford, Decatur, Early, Echols, Emanuel, Glascock, Grady, Hancock, Haralson, Heard, Jasper, Jefferson, Jenkins, Johnson, Lanier, Laurens, Lincoln, Lowndes, McDuffie, Morgan, Oglethorpe, Seminole, Taliaferro, Thomas, Tift, Turner, Upson, Ware, Warren, Washington, Wilkes and Wilkinson. *Please be sure to select a PCP in Step 1.

Anthem Bronze	Anthem Silver	Anthem Catastrophic
		Only available to applicants under age 30, unless otherwise qualified.
Pathway HMO ☐ 0% for HSA (37SR)* ☐ 4600 Online Plus (37VK)* ☐ 5200 (37SU)* ☐ 5500 (37SX)* ☐ 6750 (37T9)*	**Pathway HMO** ☐ 2100 Online Plus (37VR)* ☐ 6000 (37V1)*	**Pathway HMO** ☐ 7900 (37SM)*

Health Savings Account (HSA) Enrollment	If you choose an HSA compatible plan, you have the option to set up 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		
☐ 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)
Will this coverage be terminated or has it already been terminated? ☐ Yes ☐ No If already terminated, please give us the termination date.		**Termination date**

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 if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Dental plan options

☐ Anthem Dental Family Value (3MFZ)
☐ Prime Plan A (3965)
☐ Anthem Dental Family (3MFX)
☐ Prime Plan B (3966)
☐ Anthem Dental Family Enhanced (3MFY)
☐ Prime Plan C (3968)

Prior & other dental coverage

Name of person covered (Last, First, M.I.)	Coverage (check all that apply)	Insurer name	Insurer phone no.	Policy ID no.	Dates (if applicable) (mm/dd/yyyy)
	☐ Dental ☐ Orthodontia				**Start:** ____/____/____ **End:** ____/____/____
	☐ Dental ☐ Orthodontia				**Start:** ____/____/____ **End:** ____/____/____
	☐ Dental ☐ Orthodontia				**Start:** ____/____/____ **End:** ____/____/____
	☐ Dental ☐ Orthodontia				**Start:** ____/____/____ **End:** ____/____/____
	☐ Dental ☐ Orthodontia				**Start:** ____/____/____ **End:** ____/____/____

Vision Plan

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 if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Vision plan options

☐ Blue View Vision Bundled (381F)
☐ Blue View Vision Value (381K)
☐ Blue View Vision Enhanced (381H)
☐ Blue View Vision Plus (381J)

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 and if I paid with a money order, it will be returned to me.
- 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 and I'm responsible for all of the premium payments and making sure that all premiums are paid.
- For myself and any dependents, I'm signing here because I WANT TO GET INFORMATION ABOUT MY BENEFITS BY EMAIL OR ELECTRONICALLY. SUCH ELECTRONIC MAILINGS OR COMMUNICATIONS MAY EVEN INCLUDE CANCELLATION OR NONRENEWAL NOTICES. This may include my certificate or evidence of coverage, billing, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I also understand that by signing, information about my dependents may also be sent by email or electronically. I know I, or my enrolled dependents, can change our minds at any time and request a free copy of specific materials by mail. To do either, I (or my enrolled dependents) will update our communication preferences by going to anthem.com or calling Member Services.
- 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 at least 18 years of age; 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.

I hereby acknowledge that Anthem has informed me of the following prior to my enrollment in their health care coverage plan:

- Number, mix and location of participating/network health care providers;
- Limitations of choices of participation/network health care providers;
- Disclosure of contractual relationship between participation/network provider and Anthem.

By signing this application, I certify that the premium for my coverage will not be paid by a provider of health care services, hospital, non-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entity with a direct or indirect financial interest in the benefits of the contract/policy or an employer that offers coverage under an employer health plan. I understand that if a third party is paying my premium, Anthem may decline to accept such premium payment if it is made by a person or entity from which it is not required by law to accept.

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? ☐ Yes ☐ No If yes, make sure they fill out this section.

Agent (or broker) Certification	I certify to the best of my knowledge, the responses herein are accurate. All fields required.		
Agent/Broker signature			**Date**
Agent name (please print clearly)			
(A) Writing Agent TIN/SSN (encrypted TIN is ok)		***(B) Writing Agent/Agency/General Agency TIN** (encrypted TIN is ok)	
Agent address		**City**	**State** / **ZIP**
Agent phone no.	**Agent fax no.**	**Agent email**	

*** Field (A)** - Always provide your Writing Agent TIN/SSN. **Field (B)** - If you are a Direct Agent, with no relationship to an Agency, also enter your Agent TIN/SSN in Field (B). If this policy is sold through an Agency without a General Agency, enter the selling Agency TIN in Field (B); if this policy is sold through a General Agency, enter the General Agency TIN in Field (B).

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
   - Please make sure you submit all the pages of the application
   - 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 659960, San Antonio, TX 78265-9146 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) 837-8540.

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. If you have existing coverage and are adding one or more dependents due to marriage, birth, or adoption, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) who doesn't have current coverage.

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). One or both of the spouse(s)/domestic partner(s) must have had Minimum Essential Coverage for one or more days in the 60 days prior to the marriage/domestic partnership, unless one or both of the individuals has moved from a foreign country or U.S. territory within the 60 day period before the marriage/domestic partnership.	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*

*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.

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 ☐ Permanent move to a new service area (within the U.S.). Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move. ☐ **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.

Appendix B

Conditional Receipt

THIS RECEIPT DOES NOT PROVIDE ANY COVERAGE UNTIL ALL THE TERMS AND CONDITIONS LISTED BELOW ARE MET.

Anthem has received from the named Applicant an initial payment equal to the first month's premium together with an application for designated health insurance coverage. Such payment is accepted subject to the following conditions:

Subject to the provisions of the contract, the coverage applied for will be effective from, and the contract date as of, the day following acceptance by Anthem, unless otherwise specifically stated, provided that the payment evidenced by this receipt is the full first month's dues and provided that Anthem determines that as of the date of the application all proposed covered persons were acceptable for coverage and for the benefits applied for. If the application is not approved by Anthem said Plan shall incur no liability and the payment evidenced by this receipt will be refunded to the applicant. No one has the authority to waive or modify any of the terms or conditions of this receipt.

If you do not receive a contract within 60 days, please contact Blue Cross Blue Shield Healthcare Plan of Georgia Customer Service at 1 (855) 402-9635 or P.O. Box 105370, Atlanta, GA 30348-5370.

Abbreviated Notice Of Insurance Information Practices

PRIVACY ACT. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. We need your answers to decide if you qualify for coverage. We are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals.

ALL DATA CONFIDENTIAL. Official Code of Georgia, Code Section 33-39-5, subsection (c) (1 through 4) requires that:

1. Personal information may be collected from persons other than the individual or individuals proposed for coverage;
2. Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization;
3. A right of access and correction exists with respect to all personal information collected; and
4. The notice prescribed in subsection (c) of the above referenced Code Section will be furnished to the applicant or policyholder upon request.

ACCESS TO YOUR DATA. You have the right to see or obtain a photocopy of your personal information which we have. You also have the right to send us a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of our information practices, please contact Blue Cross Blue Shield Healthcare Plan of Georgia Customer Service at 1 (855) 402-9635 or P.O. Box 105370, Atlanta, GA 30348-5370.

Payment Methods for Individual Applications

Applicant/Member name	Primary applicant's Social Security number

Anthem Blue Cross and Blue Shield (Anthem) will accept monthly payments 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, doctors, 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.

I authorize Anthem to debit the bank account listed or charge the credit/debit card listed for my first monthly payment on or after 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 if I select Option 1 or Option 2 below, I understand that my future payments may vary as a result of changes(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. In addition, I understand if changes I make are close to the auto withdrawal date, Anthem may not be able to notify me before the withdrawal is made. **I agree to pay any service charge that Anthem may bill me because the debit/charge was not honored.** 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 Bank Account Authorization: Have your first and future monthly payments automatically deducted from your bank account.**

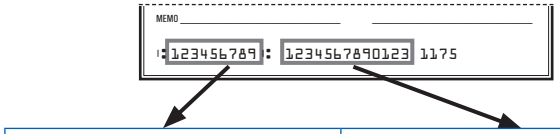
All of your monthly payments will be taken out of the **bank account** you check below.

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 authorize Anthem to automatically debit the **bank account** listed above each month to make my monthly payments. I agree that **Anthem's rights with each debit are the same as if the debit was a check that I signed**. I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem to automatically debit my account (and to make corrections to previous debits). This authority stays in effect until I let Anthem know that I no longer want them to debit my account by giving them a 30-day advance written notice. I understand that if my bank does not allow Anthem to debit my account for any reason, I will automatically be removed from automatic monthly payments and will be billed by mail. 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.

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 Credit/Debit Card Authorization: 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 authorize Anthem to automatically charge my **credit/debit card** listed below each month to make my monthly payments. I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem to charge my credit/debit card until I let them know that I no longer want them to charge my credit/debit card by giving them a 30-day advance written notice. I agree that Anthem, in honoring the monthly payments charged to my credit/debit card, is not responsible for any fees charged by my bank. I understand if that if any Anthem credit/debit transaction is not honored, I will automatically be removed from automatic monthly payments and will be billed by mail. 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.

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

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

Payment Methods for Individual Applications

Applicant/Member name	Primary applicant's Social Security number

☐ **Option 3 First Monthly Payment Only: 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 authorize Anthem to debit/charge the bank account or credit/debit 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

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (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 customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(711 :TDD/TTY)

Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo
Bee ná ahóót'i' t'áá ni nizaad k'ehjí niká a'doowoł t'áá jiik'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitínígíí béésh bee hane'í bikáá' áaji' hodíílnih. (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.

Information for Applicants Requesting a Special Enrollment Period

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.

If you have further questions about qualifying events or the supporting documentation that is required, please call your agent or customer service at 1-855-837-8540.

Supporting documentation by type of qualifying event
OFF Exchange for all SEP applicants for Anthem Blue Cross and Blue Shield (Anthem) plans

Qualifying Event	Description and examples of supporting documentation
Lost or will lose Minimum Essential Coverage: 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 supporting documentation
Lost or will lose Minimum Essential Coverage: 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 coverage (date and individuals) within the past 60 days. If the minimum essential coverage has not yet been terminated, supporting documentation must show the applicant had minimum essential coverage for one or more days in the 60 days prior to the permanent move. **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 supporting documentation
Legal guardianship or court order If you have existing coverage and are adding one or more dependents, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) that doesn't have current coverage.	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. Contact us if you are applying for a child only policy.
Gain or become a dependent through birth or adoption/placement for adoption If you have existing coverage and are adding one or more dependents, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) that doesn't have current coverage.	**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 If you have existing coverage and are adding one or more dependents, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) that doesn't have current coverage.	Certificate of marriage, domestic partnership ***Note: At least one spouse or domestic partner must either demonstrate that they had Minimum Essential Coverage or that they lived in a foreign country or US territory for one or more days in the 60 days prior to the date of the marriage or 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

Qualifying Event	Description and examples of supporting documentation
Continued	— 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
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 a 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.

Anthem

Take control of your total health with the right dental and vision coverage

The mouth and eyes are important parts of your body and your health. They can show early warning signs of disease – so regular dental and vision checkups help you stay healthy. That's why taking care of your total health requires not just medical coverage, but also dental and vision plans.

- You've probably heard before that dental health is an important part of overall health. In fact, 90% of the body's diseases first show signs and symptoms in the mouth.*
- Routine eye checkups are about more than making sure you can see clearly. They're important to health, safety and learning. Even if you think you have 20/20 vision, it's key that you're checked regularly — at every age.
- Eye exams can detect major health problems like diabetes, high blood pressure and heart disease.** Some eye diseases have no warning signs. So people may not even know their vision is at risk.***

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Getting the dental and vision plans you need

Off-exchange, standalone coverage from Anthem Blue Cross and Blue Shield (Anthem) can help you get the dental and vision care you need for your total health. Many of our dental plans cover you 100% for exams, cleanings and x-rays. All of our vision plans cover you for yearly eye exams.

All-in-one or separate plans?

You can buy a medical plan that includes dental and vision benefits — or you can buy separate plans. You may want to think about buying your dental and vision separate from your medical plan. Separate plans usually offer more choices and may have more benefits to meet your needs. The main differences are in how you apply for coverage and how you are billed.

Anthem dental plans

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

- Anthem Dental Family Value
- Anthem Dental Family
- Anthem Dental Family Enhanced
- Dental Prime for individuals and families

Anthem has one of the largest dental preferred provider organization (PPO) networks in the country.[±] Plus, we work with network dentists to get deep discounts for you. By seeing a network dentist, you can save an average of 25% to 32% on covered dental services.[Δ]

Tools that put a smile on your face

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

Ask a Hygienist

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

Dental Cost Estimator

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

Dental Health Assessment

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

Blue View Vision plans

Our Blue View Vision℠ plans are available to purchase with any Anthem Blue Cross and Blue Shield medical and/or Anthem dental plan. With all Blue View Vision plans, you can choose from more than 36,000 eye doctors at over 27,000 locations.† So you can get your eye care and eye wear just about anywhere. You can call or go online at Glasses.com, ContactsDirect or 1-800 CONTACTS®, visit a participating private practice eye doctor, or go in-store to LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and most Pearle Vision® locations.

You'll enjoy the convenience of having just one ID card when you purchase your medical, dental and/or vision plans with Anthem. You'll also get just one combined bill for all your Anthem plans.

How does health care reform affect dental and vision coverage?

Health care reform, officially known as the Affordable Care Act (ACA), requires that all Americans have a minimum amount of health insurance. This includes a list of 10 essential health benefits that must be covered by health insurance carriers. One of these is pediatric services, including dental and vision coverage.

Here's how the ACA relates to dental and vision coverage for children:

Dental

In some states, pediatric dental benefits are required to be included in ACA-compliant medical plans sold off the Marketplace (also known as the exchange). In other states, these benefits can be offered in medical plans off the Marketplace or can be provided through a separate stand-alone policy that is sold with the medical plan.

Vision

Pediatric vision coverage will be included with all ACA-compliant medical plans offered on and off the Marketplace.

Pediatric dental essential health benefits

Pediatric dental coverage is included in nearly all of our individual medical plans as of January 2014.

You have two options for buying pediatric dental essential health benefits:

- A medical plan that has pediatric dental essential health benefits coverage
- A stand-alone dental plan that includes pediatric dental essential health benefits coverage.

Pediatric vision essential health benefits

These benefits provide exams and vision materials (lenses and frames) for children.

Our plans use Blue View Vision℠ providers, which include retailers such as Glasses.com, ContactsDirect or 1-800 CONTACTS®, LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and most Pearle Vision® locations. With these plans:

- Covered children can choose from a selection of frames and contact lenses.
- Glasses with Transitions® lenses (to protect eyes from UV rays) and polycarbonate lenses with scratch coating (to protect lenses from damage) are available at no extra charge.

Should I buy "on the Marketplace" or "off the Marketplace"?

The Health Insurance Marketplace was created as part of the ACA. This is the online marketplace where you can purchase medical coverage.

If you're eligible for financial assistance to help pay for your medical coverage...and want to use it, you must get your medical plan through the Health Insurance Marketplace.

To learn more, visit your state's exchange website at **healthcare.gov**.

If you're not eligible for financial assistance, and you are shopping around for a dental or vision plan... you don't have to buy plans on the Health Insurance Marketplace. You can still buy coverage as you have in the past, through a broker or agent or directly from an insurance company.

Because there are rules for plans on the exchange, you may find that plans not on the exchange offer you more choices.

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

Our plans offer these advantages:

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

Cost shares show what the member pays	Anthem Dental Family Value		Anthem Dental Family		Anthem Dental Family Enhanced		Dental Prime Plan A	Dental Prime Plan B	Dental Prime Plan C
	(Dependents age 18 and younger)	(Adults age 19+)	(Dependents age 18 and younger)	(Adults age 19+)	(Dependents age 18 and younger)	(Adults age 19+)			
	Network / Non-network	Network / Non-network	Network / Non-network	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**	**Dental Prime**	**Dental Prime**	**Dental Prime**
Deductible (per person, all services)	**$50**	**$50**	**$50**	**$50**	**$25**	**$50**	**None**	**$50**	**$50**
Annual maximum (per person)	**None**	**$750**	**None**	**$750**	**None**	**$1,000**	**$500**	**$1,000**	**$1,250**
Annual out-of-pocket limit	**$350[1] / None**	**None**	**$350[1] / None**	**None**	**$350[1] / None**	**None**	**None**	**None**	**None**
Diagnostic and preventive	**No waiting period**	**No waiting period**	**No waiting period**	**No waiting period**	**No waiting period**	**No waiting period**	**No waiting period**	**No waiting period**	**No waiting period**
Cleaning, exams, x-rays	0% / 30% coinsurance	0% / 50% coinsurance	0% / 30% coinsurance	0% / 50% coinsurance	0% / 20% coinsurance	0% / 50% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance
Extra cleaning	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	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	**No waiting period**	**6-month waiting period**	**No waiting period**	**6-month waiting period**	**No waiting period**	**6-month waiting period**	**Not covered**	**6-month 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	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
Brush biopsy	Not covered	Covered	Not covered	Covered	Not covered	Covered	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
Complex and major services	**No waiting period**	**Not covered**	**No waiting period**	**12-month waiting period**	**No waiting period[2]**	**12-month waiting period**	**Not covered**	**12-month waiting period**	**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	Not covered	50% / 50% coinsurance	50% / 50% coinsurance
Prosthetics (crowns, dentures, bridges)	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	70% / 85% coinsurance	50% / 50% coinsurance	50% / 75% coinsurance	Not covered	Not covered	50% / 50% coinsurance
Medically necessary orthodontia	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	Not covered	Not covered	Not covered	Not covered
Cosmetic orthondontia	Not covered	Not covered	Not covered	Not covered	50% / 50% coinsurance[3]	Not covered	Not covered	Not covered	Not covered
International emergency dental program	Included	Included	Included	Included	Included	Included	Included	Included	Included
Blue View Vision	Available	Available	Available	Available	Available	Available	Available	Available	Available

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.
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.

Dental Prime for individuals and families

Our Dental Prime plans cover routine care (like exams, cleanings and x-rays) with no waiting periods, so you can use those benefits right away. Because there are three plan options, you can choose a plan that fits your needs and budget.

Our dental plans come with the International Emergency Dental Program‡

If you travel outside of the U.S., you still have access to emergency dental services. With one call, we can help you find a credentialed, English-speaking dentist for your urgent dental care needs. We can even help with translation services when you call the dentist's office. Services you get through this program don't count toward your yearly limit, if your plan has one.

Find a dentist

To find a dentist near you, go to **anthem.com/findadoctor**.

Blue View Vision coverage available

You can add Blue View Vision℠ benefits to your dental plan. These plans feature:

- **A broad, convenient group of national providers** — Blue View Vision providers include more than 36,000 private practice doctors at over 27,000 locations.† This includes online choices through Glasses.com, ContactsDirect or 1-800 CONTACTS® in addition to the nation's leading retail stores like LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and most Pearle Vision® locations.
- **A complete picture of your health between your eye doctor and your primary care doctor —** when you have a medical plan with us, every time you get care through our network, it becomes part of your health history. With Blue View Vision, your network eye doctor can access your health history information — including patient summaries, diagnoses, lab results and prescriptions. They can also securely share relevant eye health information back to your primary care doctor, while protecting your personal information. This approach helps all of your doctors in the network gain a better understanding of your whole health — leading to better, more holistic care.
- **"Add-ons" at no extra charge** — factory scratch coating on eyeglass lenses is included at no extra cost. Transitions® and polycarbonate lenses for children younger than 19 can be added at no extra cost.
- **Discounts for other "add-ons" —** includes Transitions lenses for adults at a fixed price, as well as tiered pricing for premium progressive lenses and premium anti-reflective coatings. This cuts down on your out-of-pocket costs.
- ***Value-added savings***[§] — including 15% to 40% off on unlimited purchases of most extra pairs of eye wear, conventional contact lenses, lens treatments, specialized lenses and various accessories — even after you've used all of your covered benefits.

Blue View Vision Bundled plan

Our current Blue View Vision **Bundled** plan has not changed. The Bundled plan can only be purchased in combination with any off the Marketplace individual Anthem Blue Cross and Blue Shield medical or Anthem dental plan. The Bundled plan cannot be purchased on a stand-alone basis.

Blue View Vision Enhanced, Plus and Value plans

Our stand-alone Blue View Vision **Enhanced, Plus** and **Value** plans are designed with your lifestyle in mind and can be purchased with or without a medical and/or dental plan. You can choose the plan that gives you the most value from your benefits. See your options on the next page.

Cost savings example

You'll see that when you have a Blue View Vision plan from Anthem, it often pays for itself — and then some. When it comes to Blue View Vision, seeing isn't just believing. Seeing is saving, too!

	Retail	Benefit	Copay	Member pays
Exam	$80	Covered	$20	$20
Frame	$130	$130 allowance	N/A	$0
Single vision lenses	$80	Covered		$20
Scratch coating	$22	Included	N/A	$0
Progressive premium tier 1	$140	Upgrade	N/A	$86
Polycarbonate lenses	$55	Upgrade	N/A	$40
Anti-reflective premium tier 2	$100	Upgrade	N/A	$88
Transitions lenses	$110	Upgrade	N/A	$75
Total purchase	**$717**			**$308**

Member saves $409

Blue View Vision plans

Blue View Vision Bundled*		
Vision care services	**Benefit frequency**	**Network benefit**
Eye exam (with dilation as needed)	Once every 12 months	$20 copay
Standard plastic (CR39) lenses[1]	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

* Blue View Vision **Bundled** can only be purchased with a medical and/or dental plan.

Blue View Vision Enhanced**		
Vision care services	**Benefit frequency**	**Network benefit**
Eye exam (with dilation as needed)	Once per calendar year	$10 copay
Standard plastic (CR39) lenses[1]	Once per calendar year	
Single vision		$10 copay
Bifocal		$10 copay
Trifocal		$10 copay
Contact lenses	Once per calendar year	
Elective (conventional and disposable)		$150 allowance
Non-elective		Covered in full
Frames	Once per calendar year	$150 allowance

** Blue View Vision **Enhanced** can be purchased with or without a medical and/or dental plan.

Blue View Vision Plus**		
Vision care services	**Benefit frequency**	**Network benefit**
Eye exam (with dilation as needed)	Once per calendar year	$10 copay
Standard plastic (CR39) lenses[1]	Once per calendar year	
Single vision		$20 copay
Bifocal		$20 copay
Trifocal		$20 copay
Contact lenses	Once per calendar year	
Elective (conventional and disposable)		$130 allowance
Non-elective		Covered in full
Frames	Once every other calendar year	$130 allowance

** Blue View Vision **Plus** can be purchased with or without a medical and/or dental plan.

Blue View Vision Value**		
Vision care services	**Benefit frequency**	**Network benefit**
Eye exam (with dilation as needed)	Once per calendar year	$20 copay
Standard plastic (CR39) lenses[1]	Once per calendar year	
Single vision		$20 copay
Bifocal		$20 copay
Trifocal		$20 copay
Contact lenses	Once per calendar year	
Elective (conventional and disposable)		$80 allowance
Non-elective		Covered in full
Frames	Once every other calendar year	$130 allowance

** Blue View Vision **Value** can be purchased with or without a medical and/or dental plan.

1 Factory scratch coating is covered at no extra cost. Polycarbonate and Transitions lenses are covered for children under age 19.

Save time and money with smart provider choices

While all PPO plans allow you to see any doctor, you can save money by choosing a network doctor.

	Network dentist	Non-network dentist
What you pay the dentist	◦ Your deductible ◦ The percentage that's not covered by your insurance	◦ Your deductible ◦ The percentage that's not covered by your insurance ◦ The difference between what the dentist charges and the total amount we allow to be paid for a service
Claims paperwork	◦ Your dentist sends claims to us ◦ We pay the dentist directly	◦ You or your dentist may submit your claims to us ◦ We pay you or your dentist for covered expenses

You may pay more for care if you choose a non-network doctor. Here's why:

- Network doctors have agreed, by contract, to special payment rates for services and cannot charge you more than these negotiated rates. If you have coinsurance or a deductible, you pay those amounts.
- Non-network doctors don't have a contract with us. They can charge you the difference between the total amount we allow to be paid for a service and the amount they normally charge for a service (plus your coinsurance or deductible). That means higher costs for you.

How to enroll

Sign up today for our dental and vision plans!

Online: Go to **anthem.com** and select **Shop For Insurance** to get your free quote and enroll.

Paper: Fill out and sign the appropriate form. Then, give the form to your broker or agent or mail it to us at the address listed on the form.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (1-855-738-6652 / 1-855-837-8540). (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 (1-855-738-6652 / 1-855-837-8540). (TTY/TDD: 711)

Amharic
ይህንን ሰነድ ለመረዳት በአማራጭ ቋንቋ እርዳታ ማግኘት ከፈለጉ፣ የአባል አገልግለቶች ቁጥርን (1-855-738-6652 / 1-855-837-8540) **በመደወል ያለምንም ክፍያ ማግኘት ይችላሉ።** (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء. (1-855-738-6652 / 1-855-837-8540) (TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(1-855-738-6652 / 1-855-837-8540)請求免費協助。(TTY/TDD: 711)

Farsi
در صورتی که برای درک این سند به زبانی دیگر نیازمند کمک هستید،
می‌توانید بدون هیچ هزینه اضافی این را درخواست کنید. برای این کار با
مرکز خدمات اعضاء به شماره 1-855-738-6652 / 1-855-837-8540 تماس بگیرید، (TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 1-855-738-6652 / 1-855-837-8540. (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 (1-855-738-6652 / 1-855-837-8540). (TTY/TDD: 711)

Gujarati
વૈકલ્પિક ભાષામાં આ દસ્તાવેજો સમજવામાં તમને કોઈ મદદની જરૂર હોય તો તમે મેમ્બર સર્વિસ નંબર (1-855-738-6652 / 1-855-837-8540). પર કૉલ કરીને કોઈપણ વધારાના ખર્ચ વિના વિનંતી કરી શકો છો. (TTY/TDD: 711)

Haitian
Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (1-855-738-6652 / 1-855-837-8540). (TTY/TDD: 711)

Hindi
अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (1-855-738-6652 / 1-855-837-8540) 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（1-855-738-6652 / 1-855-837-8540）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(1-855-738-6652 / 1-855-837-8540)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Portuguese-Europe
Se necessitar de ajuda para compreender este documento noutro idioma, poderá solicitá-la gratuitamente ligando para o número dos Serviços para Membros (1-855-738-6652 / 1-855-837-8540). (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (1-855-738-6652 / 1-855-837-8540). (TTY/TDD: 711)

Vietnamese
Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (1-855-738-6652 / 1-855-837-8540). (TTY/TDD: 711)

Notes

Notes

Notes

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.

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

* Academy of General Dentistry Know Your Teeth website: *Warning Signs in the Mouth Can Save Lives* (accessed August 2015); knowyourteeth.com.
**All About Vision website: *Why Are Eye Exams Important?* (May 2011): allaboutvision.com/eye-exam/importance.htm.
***American Academy of Ophthalmology website: Eye Diseases (March 13, 2008) geteyesmart.org.
± Network data from Strenuus, August 2016.
Δ Internal data, 2015.
† Blue View Vision internal data, 2016.
‡ The International Emergency Dental Program is managed by DeCare Dental. DeCare Dental is an independent company offering dental management services to Anthem Blue Cross and Blue Shield.
§ Laws in some states may prohibit network providers from discounting products and services that are not covered benefits.

Individual dental and vision premiums for Georgia

For policies with effective dates of January 1, 2019 through December 31, 2019

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

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

Anthem Dental plans

The child/children rates shown in the charts below are defined as dependent children ages 0-18. Any enrollees age 19 and older use the adult rates, including dependent children over the age of 18. For a family, each adult (including dependent children ages 21-26) are rated first, and then up to the three eldest children ages 0-20. You will not be charged premiums for more than three children between the age of 0-20, even if there are more children covered by the plan.

Note that the charts below provide pricing for many of the most common family units. For other combinations, please talk to your broker or sales representative.

Anthem Dental Family Value (monthly payments)

One child	$19.20
One adult	$17.64
One adult + one child	$36.84
One adult + two children	$56.04
One adult + three or more children	$75.24
Two adults + one child	$54.48
Two adults + two children	$73.68
Two adults + three or more children	$92.88

Anthem Dental Family (monthly payments)

One child	$19.20
One adult	$21.69
One adult + one child	$40.89
One adult + two children	$60.09
One adult + three or more children	$79.29
Two adults + one child	$62.58
Two adults + two children	$81.78
Two adults + three or more children	$100.98

Anthem Dental Family Enhanced (monthly payments)

One child	$27.50
One adult	$31.04
One adult + one child	$58.54
One adult + two children	$86.04
One adult + three or more children	$113.54
Two adults + one child	$89.58
Two adults + two children	$117.08
Two adults + three or more children	$144.58

Dental Prime (monthly payments)

	Plan A		Plan B		Plan C	
	Under age 65	Age 65 and over	Under age 65	Age 65 and over	Under age 65	Age 65 and over
Individual	$28.45	$29.60	$41.90	$44.80	$51.95	$59.25
Individual + one	$55.30	$57.50	$81.45	$87.15	$101.05	$115.20
Family	$88.45	$92.00	$130.30	$139.40	$161.65	$184.30

Blue View Vision℠ (monthly payments)

This vision rider is available when purchased with any Anthem medical and/or dental plans.

Individual	$7.83
Individual + one	$13.71
Family	$21.94

Anthem

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

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

Blue View Vision: Individual vision premiums for Georgia

For policies with effective dates of January 1 through December 31, 2019

We know you have choices when it comes to health care coverage. So why choose us for your vision plan? How about for convenience, choice and savings — right before your eyes!

With our stand-alone **Blue View Vision℠ Enhanced, Blue View Vision Plus** and **Blue View Vision Value** plans, you'll get convenience and lots of choices. Our large provider network of more than 38,000 eye doctors at over 27,000 locations makes it easy to find a doctor or eye care retailer near your home or work.*

Blue View Vision monthly payments

	Three-tier structure		
Vision plan	Individual only	Individual + 1	Family
Blue View Vision Enhanced	$19.98	$34.96	$55.94
Blue View Vision Plus	$15.48	$27.10	$43.35
Blue View Vision Value	$12.63	$22.10	$35.37

* Anthem internal data, 2016.

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

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Peace of mind made easy

Anthem individual term life insurance — affordable and no exam needed

Life insurance is an important decision, but it doesn't have to be a complicated one.

You want your loved ones to be taken care of — even if you're not here to provide for them. That's why it's important to have life insurance to help your family with expenses when the unexpected happens. Anthem individual term life insurance plans can give your family peace of mind for their future. While you may not want to think about it, there's actually no better time than now to protect your family.

To make things even better, we've made it simpler to get coverage:

- There's no medical exam required.
- If you also have a health plan with us, you'll only get one bill for health and life coverage.
- Life insurance is available with Anthem's health coverage or without — it's your choice.

Our individual term life plans include two coverage options: $25,000 and $50,000.

You can choose the coverage amount that fits your needs. Individuals between the ages of 18 and 64 are eligible to apply.

Take a look at how much each plan would cost you:

Anthem individual term life monthly rates

Age	$25,000	$50,000
18-19	$2.50	$5.00
20-29	$4.65	$9.30
30-39	$5.40	$10.80
40-49	$12.50	$25.00
50-59	$34.80	$69.60
60-64	$49.00	$98.00

Want to know more?

Go to anthem.com for more information or to apply for life insurance. Or call 1-877-206-0913 with any questions.

Anthem

AnthemLife

The initial rates for term life insurance are based on your age at the time the policy is issued and are subject to change in accordance with the published rate table. The policy is issued for a one-year term, renewable at the policyholder's option. Term life insurance is subject to the written provisions of the policy. The policy contains exclusions and limitations, including the exclusion for death due to suicide for the first two years the policy is in force. The policy will terminate at age 65.

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Your prescription drug benefits

Anthem plans help keep you healthy and lower your health care costs

Your medications — covered

All of our pharmacy plans have a drug list that includes hundreds of covered brand-name and generic drugs in every category and class, meeting or exceeding Affordable Care Act (ACA) requirements. Individual and family plans use the Select Drug List.

To view the Select Drug List and see if your drug is covered, go to bcbsga.com/pharmacyinformation and choose the Georgia ***Individual*** **Select Drug List.**

Filling your prescriptions

It's simple. Choose the way that works best for you to get the medicines you need, when you need them.

Home delivery pharmacy – your medicine delivered right to your door

We offer home delivery to make it easier for you to get your medicine quickly and safely. People who use home delivery pharmacy are more likely to follow their drug treatment plan, resulting in increased medication adherence. That means fewer doctor visits and hospital stays — and lower health care costs for you.[1]

Retail pharmacies in your network

The **Rx Choice Tiered Network** offers two levels of pharmacies — giving you choices, convenience and savings:

Level 1	Get the lowest cost for your prescriptions when you use one of nearly 25,000 Level 1 network pharmacies, including **CVS, Target, Wal-Mart, Kroger** and **Costco**.
Level 2	You can also use one of the 45,000+ Level 2 network pharmacies. Your prescriptions will be covered, but you'll pay an additional copay or coinsurance.

Our **National Pharmacy Network** includes nearly 70,000 retail pharmacies — making it easy for you to get prescriptions filled near your home or work, or even when you travel.

Anthem®

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Your pharmacy benefits — easy to manage at anthem.com

Manage all your prescription benefits in one place. It's easy. It's convenient. And you can do things like:

- Find out if your drug is covered. Go to **bcbsga.com/pharmacyinformation** and choose the ***Individual* Select Drug List.**
- See if your preferred pharmacy is in the plan's network.

  Visit **bcbsga.com/pharmacyinformation/rxnetworks.html** to see all of the pharmacies in our networks, including Level 1 pharmacies where you can save the most money.
- Learn more about your pharmacy benefits — including why some drugs need preapproval to be covered — by going to our frequently asked questions (FAQs) at **bcbsga.com/faqs/bcbsga/pharmacy**.

On the go, too! Most of the same helpful tools are available on your cell phone or other mobile device with the Anthem Anywhere app. You can manage your drug benefits wherever you are, whenever you need to.

Medical + pharmacy — better and easier than ever

With our combined medical and pharmacy benefits, your doctor can see the whole picture of your health. For you, this means:

- Better overall health.
- A smoother experience.
- Fewer hospital stays and lower medical costs.[2]
- Saving more on prescription drugs.[2]

1 Examination of the Link Between Medication Adherence and Use of Mail-Order Pharmacies in Chronic Disease States, Journal of Managed Care & Specialty Pharmacy, Nov. 2016.
2 Integrating pharmacy with medical benefits can help your bottom line, Smart Business Online (sbonline.com), Apr. 2015.
This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the <enter contract name> may be continued in force or discontinued. For more information, review the <enter contract name>, call your Anthem Sales representative or go to anthem.com.

Anthem®