

Anthem Blue Cross and Blue Shield

Anthem Silver Pathway X HMO 4250/30% S04

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016 – 12/31/2016
Coverage for: Individual + Family | Plan Type: HMO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <https://eoc.anthem.com/eocdps/1X2PIND01012016> or by calling (855) 748-1808.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$3,250 person / \$6,500 family for In-Network Providers. Does not apply to Prescription Drugs, Preventive Care, Primary Care visit, and Specialist visit.	You must pay all costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes; \$1,000 person / \$2,000 family for In-Network Providers Tier 2, Tier 3 and Tier 4 Prescription Drugs. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes; \$4,250 person / \$8,500 family for In-Network Providers.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, Balance-Billed charges, and Health Care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes, Pathway X HMO. For a list of In-Network providers, see www.anthem.com or call (855) 748-1808. Dental and Vision benefits may access	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 3 for how this

Questions: Call (855) 748-1808 or visit us at www.anthem.com

OH/I/F/Anthem Silver Pathway X HMO 4250/30% S04/1X2P/NA/01-16

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call (855) 748-1808 to request a copy.

Important Questions	Answers	Why this Matters:
	a different network of providers.	plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u>?	No; you do not need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <u>excluded services</u> .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-Network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay per visit	Not covered	-----none-----
	Specialist visit	\$50 copay per visit	Not covered	-----none-----
	Other practitioner office visit	Chiropractor 30% coinsurance Acupuncture Not covered	Chiropractor Not covered Acupuncture Not covered	Chiropractor Coverage for In-Network Providers is limited to 12 visits per benefit period. Acupuncture -----none-----
	Preventive care/screening/immunization	No charge	Not covered	-----none-----
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office 30% coinsurance X-Ray – Office 30% coinsurance	Lab – Office Not covered X-Ray – Office Not covered	Lab – Office -----none----- X-Ray – Office -----none-----
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not covered	-----none-----
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.anthem.com/pharmacyin	Tier1 - Typically Generic	\$15 copay per prescription (retail only) and \$30 copay per prescription (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs. Maintenance medications are subject to mandatory home delivery services after the initial supply has been dispensed at a retail pharmacy.

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
formation/				Applies to all tiers.
Anthem Select Drug List	Tier2 - Typically Preferred / Brand	\$40 copay per prescription (retail only) and \$100 copay per prescription (home delivery only)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier3 - Typically Non-Preferred / Specialty Drugs	50% coinsurance (retail and home delivery)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier4 - Typically Specialty Drugs	50% coinsurance (retail and home delivery)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 30 day supply (home delivery program). No coverage for non-formulary drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not covered	-----none-----
	Physician/surgeon fees	30% coinsurance	Not covered	-----none-----
If you need immediate medical attention	Emergency room services	30% coinsurance	Covered as In-Network	-----none-----
	Emergency medical transportation	30% coinsurance	Covered as In-Network	-----none-----
	Urgent care	\$90 copay per visit	Covered as In-Network	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay per admission and then 30% coinsurance	Not covered	Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs In-Network Providers is limited to 60 days per benefit period.
	Physician/surgeon fee	30% coinsurance	Not covered	-----none-----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit 30% coinsurance Mental/Behavioral Health Facility Visit - Facility Charges 30% coinsurance	Mental/Behavioral Health Office Visit Not covered Mental/Behavioral Health Facility Visit - Facility Charges Not covered	Mental/Behavioral Health Office Visit -----none----- Mental/Behavioral Health Facility Visit - Facility Charges -----none-----
	Mental/Behavioral health inpatient services	\$500 copay per admission and then	Not covered	-----none-----

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
		30% coinsurance		
	Substance use disorder outpatient services	Substance Use Office Visit 30% coinsurance Substance Use Facility Visit - Facility Charges 30% coinsurance	Substance Use Office Visit Not covered Substance Use Facility Visit - Facility Charges Not covered	Substance Use Office Visit -----none----- Substance Use Facility Visit - Facility Charges -----none-----
	Substance use disorder inpatient services	\$500 copay per admission and then 30% coinsurance	Not covered	-----none-----
If you are pregnant	Prenatal and postnatal care	30% coinsurance	Not covered	-----none-----
	Delivery and all inpatient services	\$500 copay per admission and then 30% coinsurance	Not covered	Applies to inpatient facility. Other cost shares may apply depending on services provided.
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not covered	Coverage for In-Network Providers is limited to 100 visits per benefit period.
	Rehabilitation services	30% coinsurance	Not covered	Coverage for Physical Therapy is limited to 20 visits per benefit period, Speech Therapy is limited to 20 visits per benefit period, and Occupational Therapy is limited to 20 visits per benefit period. Apply to In-Network Providers.
	Habilitation services	30% coinsurance	Not covered	Habilitation and Rehabilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	30% coinsurance	Not covered	Coverage for In-Network Providers is limited to 90 days per benefit period.
	Durable medical equipment	30% coinsurance	Not covered	-----none-----
	Hospice service	30% coinsurance	Not covered	-----none-----
If your child needs dental or eye care	Eye exam	No charge	Not covered	Coverage for In-Network Providers is limited to 1 exam per benefit period.
	Glasses	No charge	Not covered	Coverage for In-Network Providers is limited to 1 unit per benefit period.
	Dental check-up	10% coinsurance	Not covered	Frequencies and limitations for this

Common Medical Event	Services You May Need	Your Cost if You Use an In-Network Provider	Your Cost if You Use an Non-Network Provider	Limitations & Exceptions
				service may vary.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Non-Formulary drugs
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care Coverage is limited to 12 visits per benefit period.
- Private-duty nursing Coverage is limited to 90 visits per benefit period.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at (855) 748-1808. You may also contact your state insurance department at:

Ohio Department of Insurance
50 W. Town Street
Third Floor - Suite 300
Columbus, Ohio 43215
(800) 686-1526
(614) 644-2673

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

ATTN: Grievances and Appeals
P.O. Box 105568
Atlanta GA 30348-5568

Ohio Department of Insurance
50 W. Town Street
Third Floor - Suite 300
Columbus, Ohio 43215
(800) 686-1526
(614) 644-2673

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Language Access Services:

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íínízinigo t'áá diné k'éjígó, t'áá shoodí ba na'alníhí ya sidáhí bich'í naabídíílkíid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'í hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígú ní béesh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'í hodiilní.

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$3,240
- Patient pays \$4,300

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$3,300
Copays	\$600
Coinsurance	\$400
Limits or exclusions	\$0
Total	\$4,300

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$2,570
- Patient pays \$2,830

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,200
Copays	\$1,200
Coinsurance	\$30
Limits or exclusions	\$400
Total	\$2,830

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co payments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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