# Anthem Blue Cross and Blue Shield
# Anthem Silver Pathway X 2250/50%

**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:** PPO

**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/1XB6IND01012016 or by calling (855) 738-6677.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$2,250** person / **$4,500** family for Network Providers. Does not apply to Preventive Care, Primary Care visit, and Specialist visit. **$4,500** person / **$9,000** family for Out-of-Network Providers. | You must pay all costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes; **$6,650** person / **$13,300** family for Network Providers. **$13,300** person / **$26,600** family for Out-of-Network Providers. | The **out-of-pocket limit** 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 out–of–pocket limit?** | Pre-cert penalties, Premiums, Balance-Billed charges, Non-Network Transplant, and Health Care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out–of–pocket limit**. |
| **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 *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes, Pathway X. For a list of Network providers, see www.anthem.com or call | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an |

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| | **(855) 738-6677**. Dental and Vision benefits may access a different network of providers. | out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No; you do not need a referral to see a specialist. | You can see the **specialist** 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 **excluded services.** |

- **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**.)

| Common Medical Event | Services You May Need | Your Cost if You Use a Network Provider | Your Cost if You Use a 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 | 50% coinsurance | --------none-------- |
| | Specialist visit | 50% coinsurance | 50% coinsurance | --------none-------- |
| | Other practitioner office visit | Chiropractor<br>50% coinsurance<br>Acupuncture<br>Not covered | Chiropractor<br>50% coinsurance<br>Acupuncture<br>Not covered | Chiropractor<br>Coverage for Network Provider and Non-Network Provider are combined is limited to 26 visits per benefit period.<br>Acupuncture<br>--------none-------- |
| | Preventive care/screening/immunization | No charge | 50% coinsurance | Immunizations for children prior to their 6th birthday have no cost share for In-Network and Non-Network charges. Costs may vary by site of service. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab – Office<br>50% coinsurance<br>X-Ray – Office<br>50% coinsurance | Lab – Office<br>50% coinsurance<br>X-Ray – Office<br>50% coinsurance | Lab – Office<br>Costs may vary by site of service.<br>X-Ray – Office<br>Costs may vary by site of service. |
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance | 50% coinsurance | Costs may vary by site of service. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription** | Tier1 - Typically Generic | $15 copay per prescription (retail only) and $30 copay per prescription (home delivery only) | 50% coinsurance (retail only 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. |
| | Tier2 - Typically Preferred / Brand | $40 copay per | 50% coinsurance (retail | Covers up to a 30 day supply (retail |

| Common Medical Event | Services You May Need | Your Cost if You Use a Network Provider | Your Cost if You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **drug coverage** is available at http://www.anthem.com/pharmacyinformation/<br><br>Anthem Select Drug List | | prescription (retail only) and $100 copay per prescription (home delivery only) | only home delivery not covered) | 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) | 50% coinsurance (retail only 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) | 50% coinsurance (retail only 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) | 50% coinsurance | 50% coinsurance | --------none-------- |
| | Physician/surgeon fees | 50% coinsurance | 50% coinsurance | --------none-------- |
| **If you need immediate medical attention** | Emergency room services | $500 copay per visit and then 50% coinsurance | Covered as In-Network | Copay waived if admitted. |
| | Emergency medical transportation | 50% coinsurance | Covered as In-Network | --------none-------- |
| | Urgent care | $75 copay per visit and then 50% coinsurance | Covered as In-Network | --------none-------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $500 copay per admission and then 50% coinsurance | $1,000 copay per admission and then 50% coinsurance | Coverage for Inpatient physical medicine and rehabilitation including day rehabilitation programs Network Provider and Non-Network Provider are combined is limited to 60 days per benefit period. |
| | Physician/surgeon fee | 50% coinsurance | 50% coinsurance | --------none-------- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Mental/Behavioral Health Office Visit<br>50% coinsurance<br>Mental/Behavioral Health Facility Visit - Facility Charges<br>50% coinsurance | Mental/Behavioral Health Office Visit<br>50% coinsurance<br>Mental/Behavioral Health Facility Visit - Facility Charges<br>50% coinsurance | Mental/Behavioral Health Office Visit<br>--------none--------<br>Mental/Behavioral Health Facility Visit - Facility Charges<br>--------none-------- |
| | Mental/Behavioral health inpatient services | $500 copay per admission and then | $1,000 copay per admission and then 50% | --------none-------- |

| Common Medical Event | Services You May Need | Your Cost if You Use a Network Provider | Your Cost if You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | | 50% coinsurance | coinsurance | |
| | Substance use disorder outpatient services | Substance Use Office Visit<br>50% coinsurance<br>Substance Use Facility Visit - Facility Charges<br>50% coinsurance | Substance Use Office Visit<br>50% coinsurance<br>Substance Use Facility Visit - Facility Charges<br>50% coinsurance | Substance Use Office Visit<br>--------none--------<br>Substance Use Facility Visit - Facility Charges<br>--------none-------- |
| | Substance use disorder inpatient services | $500 copay per admission and then 50% coinsurance | $1,000 copay per admission and then 50% coinsurance | --------none-------- |
| **If you are pregnant** | Prenatal and postnatal care | 50% coinsurance | 50% coinsurance | --------none-------- |
| | Delivery and all inpatient services | $500 copay per admission and then 50% coinsurance | $1,000 copay per admission and then 50% coinsurance | 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 | 50% coinsurance | 50% coinsurance | Coverage for Network Provider and Non-Network Provider are combined is limited to 90 visits per benefit period. |
| | Rehabilitation services | 50% coinsurance | 50% coinsurance | Coverage for Physical Therapy is limited to 20 visits per benefit period and Occupational Therapy is limited to 20 visits per benefit period. Apply to Network Provider and Non-Network Provider are combined. For Covered Services you receive in the office from a Physical Therapist, you will not have to pay an office visit Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician. |
| | Habilitation services | 50% coinsurance | 50% coinsurance | For Covered Services you receive in the office from a Physical Therapist, you will not have to pay an office visit Copayment or Coinsurance that is higher than what you would pay for a Primary Care Physician. Habilitation and Rehabilitation visits count |

| Common Medical Event | Services You May Need | Your Cost if You Use a Network Provider | Your Cost if You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | | | | towards your Rehabilitation limit. |
| | Skilled nursing care | 50% coinsurance | 50% coinsurance | Coverage for Network Provider and Non-Network Provider are combined is limited to 90 days per benefit period. |
| | Durable medical equipment | 50% coinsurance | 50% coinsurance | --------none-------- |
| | Hospice service | 50% coinsurance | 50% coinsurance | --------none-------- |
| **If your child needs dental or eye care** | Eye exam | No charge | No charge | Coverage for Network Provider and Non-Network Provider are combined is limited to 1 exam per benefit period. Coverage for Non-Network Providers is limited to $30 maximum benefit per visit. Plan covers Vision for Covered Members through age 18. |
| | Glasses | No charge | No charge | Coverage for Network Provider and Non-Network Provider are combined is limited to 1 unit per benefit period. Coverage for bifocal lenses is limited to $40 maximum benefit per occurrence, single vision lenses is limited to $25 maximum benefit per occurrence, trifocal lenses is limited to $55 maximum benefit per occurrence, and frames is limited to $45 maximum benefit per occurrence. Apply to Non-Network Providers. |
| | Dental check-up | 10% coinsurance | 10% coinsurance | Frequencies and limitations for this 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)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 26 visits per benefit period.
- Hearing aids Coverage for left ear is limited to 1 unit every 36 months and right ear is limited to 1 unit every 36 months.
- Private-duty nursing Coverage is limited to 82 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) 738-6677. You may also contact your state insurance department at:

Missouri Department of Insurance
Consumer Complaints
P.O. Box 690
Jefferson City, MO 65102-0690
(800) 726-7390

## 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

Missouri Department of Insurance
Consumer Complaints
P.O. Box 690
Jefferson City, MO 65102-0690
(800) 726-7390

Missouri Department of Insurance
301 W. High Street, Room 830
Harry S. Truman State Office Building
Jefferson City, MO 65101
(800) 726-7390
www.insurnace.mo.gov
consumeraffairs@insurance.mo.gov

## 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 adoolwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'alníhí ya sidáhí bich'į naabídíilkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į 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** $2,340
- **Patient pays** $5,200

**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 | $2,300 |
| Copays | $700 |
| Coinsurance | $2,200 |
| Limits or exclusions | $0 |
| **Total** | $5,200 |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,100
- **Patient pays** $2,300

**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 | $500 |
| Copays | $1,600 |
| Coinsurance | $0 |
| Limits or exclusions | $200 |
| **Total** | $2,300 |

# 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.

**Questions:** Call (855) 738-6677 or visit us at www.anthem.com



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) 738-6677 to request a copy.