Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: BlueAdvantage HMO MD Pathway Network $15/45/75/30% Essential Tiered Rx

Your Network: Pathway - HMO

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care, and medical services for urgent/acute care	No charge deductible does not apply
Mental Health & Substance Use Disorder Services	No charge deductible does not apply
Specialist care	$50 copay per visit deductible does not apply

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	$3,000 member / $6,000 family	Not covered
Overall Out-of-Pocket Limit	$5,500 member / $11,000 family	Not covered
The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per member deductible and per member out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per member deductible or per member out-of-pocket limit. All medical and prescription drug deductibles, copayments and coinsurance apply to the out-of-pocket limit.		
Doctor Visits (virtual and office) *Your plan requires the selection of a Primary Care Physician (PCP).*		
Primary Care (PCP) and Mental Health and Substance Use Disorder Services *virtual and office*	$25 copay per visit deductible does not apply	Not covered
Specialist Care *virtual and office*	$50 copay per visit deductible does not apply	Not covered
Other Practitioner Visits **Routine Maternity Care** (Prenatal and Postnatal)	$300 copay per pregnancy deductible does not apply	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic *for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.*	$25 copay per visit deductible does not apply	Not covered
Spinal Manipulation *Coverage is limited to 20 visits per benefit period.*	$25 copay per visit deductible does not apply	Not covered
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$25 copay per visit deductible does not apply	Not covered
Other Services in an Office		
Allergy Testing	20% coinsurance after deductible is met	Not covered
Prescription Drugs *Dispensed in the office*	20% coinsurance after deductible is met	Not covered
Surgery	20% coinsurance after deductible is met	Not covered
Preventive care / screenings / immunizations	No charge	Not covered
Preventive Care for Chronic Conditions *per IRS guidelines*	No charge	Not covered
Diagnostic Services **Lab**		
Office	20% coinsurance after deductible is met	Not covered
Freestanding Lab/Reference Lab	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
X-Ray		
Office	20% coinsurance after deductible is met	Not covered
Freestanding Radiology Center	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	20% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Freestanding Radiology Center	20% coinsurance after deductible is met	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Emergency and Urgent Care		
Urgent Care *includes doctor services. Additional charges may apply depending on the care provided.* *There may be other levels of cost share that are contingent on how services are provided.*	$50 copay per visit deductible does not apply	Not covered
Emergency Room Facility Services *Your copay will be waived if admitted.*	$400 copay per visit and then 20% coinsurance after deductible is met	Covered as In-Network
Emergency Room Doctor and Other Services *There may be other levels of cost share that are contingent on how services are provided.*	20% coinsurance after deductible is met	Covered as In-Network
Ambulance	20% coinsurance after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	20% coinsurance after deductible is met	Not covered
Doctor Services	20% coinsurance after deductible is met	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	20% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	20% coinsurance after deductible is met	Not covered
Physician and other services *including surgeon fees*		
Hospital	20% coinsurance after deductible is met	Not covered
Ambulatory Surgical Center	20% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services)		
Facility Fees	20% coinsurance after deductible is met	Not covered
Physician and other services *including surgeon fees*	20% coinsurance after deductible is met	Not covered
Home Health Care *Coverage is limited to 100 visits per benefit period. Limits are combined for all home health services.*	20% coinsurance after deductible is met	Not covered
Rehabilitation and Habilitation services *including physical, occupational and speech therapies.* *Coverage for physical and occupational therapies combined is limited to 40 visits combined per benefit period. Coverage for speech therapy is limited to 20 visits per benefit period. Costs may vary by site of service. Office and outpatient visits count towards your rehabilitation limit.*		
Office	$25 copay per visit deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Pulmonary rehabilitation *office and outpatient hospital*	20% coinsurance after deductible is met	Not covered
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$25 copay per visit deductible does not apply	Not covered
Outpatient Hospital	20% coinsurance after deductible is met	Not covered
Dialysis/Hemodialysis *office and outpatient hospital*	20% coinsurance after deductible is met	Not covered
Chemo/Radiation Therapy *office and outpatient hospital*	20% coinsurance after deductible is met	Not covered
Skilled Nursing Care (facility) *Coverage for Inpatient rehabilitation and skilled nursing services is limited to 150 days combined per benefit period.*	20% coinsurance after deductible is met	Not covered

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Inpatient Hospice	20% coinsurance after deductible is met	Not covered
Durable Medical Equipment	20% coinsurance after deductible is met	Not covered
Prosthetic Devices *Coverage for wigs is limited to 1 item after cancer treatment up to a $500 maximum per member.*	20% coinsurance after deductible is met	Not covered

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
Pharmacy Deductible	Not applicable	Not applicable	Not covered
Pharmacy Out-of-Pocket Limit	Combined with In-Network medical out-of-pocket limit	Combined with In-Network medical out-of-pocket limit	Not covered
Prescription Drug Coverage **Network:** ***Rx Choice Tiered Network*** **Drug List:** ***Essential*** *Drugs not included on the Essential drug list will not be covered.*			
Day Supply Limits: **Retail Pharmacy** *30 day supply (cost shares noted below)* **Retail 90 Pharmacy** *90 day supply (3 times the 30 day supply cost share(s) charged at Preferred Network and In-Network Retail Pharmacies noted below applies).* **Home Delivery Pharmacy** *90 day supply (maximum cost shares noted below). Maintenance medications are available through CarelonRx Pharmacy. You may get two 30-day supply fills of the same maintenance medication at a retail pharmacy. Prior to your 3rd fill, you must call us on the number on your ID card and tell us if you would like to keep getting your maintenance medications from a retail pharmacy or if you would like to use home delivery. If you do not contact us, you will pay the full retail cost of any maintenance medication until you inform us of your decision.* **Specialty Pharmacy** *30 day supply (cost shares noted below for retail and home delivery apply). We may require certain drugs with special handling, provider coordination or patient education be filled by our designated specialty pharmacy. Drug cost share assistance programs may be available for certain specialty drugs.*			
Tier 1 - Typically Generic	$15 copay per prescription (retail) and $37.50 copay per prescription (home delivery)	$25 copay per prescription (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	$45 copay per prescription (retail) and $135 copay per prescription (home	$55 copay per prescription (retail) and Not covered (home delivery)	Not covered (retail and home delivery)

Covered Prescription Drug Benefits	Cost if you use a Preferred Network Pharmacy	Cost if you use an In-Network Pharmacy	Cost if you use a Non-Network Pharmacy
	delivery)		
Tier 3 - Typically Non-Preferred Brand	$75 copay per prescription (retail) and $225 copay per prescription (home delivery)	$85 copay per prescription (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	30% coinsurance up to $500 per prescription (retail and home delivery)	30% coinsurance up to $600 per prescription (retail) and Not covered (home delivery)	Not covered (retail and home delivery)

Notes:

- The Primary Care Physician and Specialist office visit cost share applies to both office and facility based office visits for evaluation and management services only.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- The limits for physical, occupational, and speech therapy, if any apply to this plan, will not apply if you get care as part of the Mental Health and Substance Use Disorder benefit.

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Questions: (877) 811-3106 or visit us at www.anthem.com

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This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

By signing this Summary of Benefits, I agree to the benefits for the product selected as of the effective date indicated.

Authorized group signature (if applicable)	Date
Underwriting signature (if applicable)	Date

Language Access Services:

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you have any questions about this document, you have the right to get help and information in your language at no cost. To talk to an interpreter, call (877) 811-3106

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.

(TTY/TDD: 711)

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (877) 811-3106.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (877) 811-3106:

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Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (877) 811-3106.

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Navajo (Diné): Díí naaltsoos biká'ígíí łahgo bína'ídíłkidgo ná bohónéedzą́ dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee nił hodoonih t'áadoo bą́ą́h ílínígóó. Ata' halne'ígíí ła' bich'į' hadeesdzih nínízingo kojį' hodíílnih (877) 811-3106.

Language Access Services:

Polish (polski): W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer: (877) 811-3106.

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