Your summary of benefits

Anthem® Blue Cross and Blue Shield

Your Plan: Anthem Link Pathway HMO 6000/$30/$90/8500 Rx $0/$10/$60/$125/$400 Ded T3/T3 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	$90 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	$6,000 member / $12,000 family	Not covered
Overall Out-of-Pocket Limit	$8,500 member / $17,000 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*	**virtual-**No charge **office-**$30 copay per visit deductible does not apply	Not covered
Specialist Care *virtual and office*	$90 copay per visit deductible does not apply	Not covered
Other Practitioner Visits		
Routine Maternity Care (Prenatal and Postnatal)	$500 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.*	$30 copay per visit deductible does not apply	Not covered
Spinal Manipulation *Coverage is limited to 20 visits per benefit period.*	$30 copay per visit deductible does not apply	Not covered
Acupuncture *Coverage is limited to 20 visits per benefit period.*	$30 copay per visit deductible does not apply	Not covered
Other Services in an Office		
Allergy Testing	$90 copay per visit deductible does not apply‡	Not covered
Prescription Drugs *Dispensed in the office*	$400 copay per visit deductible does not apply	Not covered
Surgery	$90 copay per visit deductible does not apply‡	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	$90 copay per visit deductible does not apply‡	Not covered
Freestanding Lab/Reference Lab	No charge	Not covered
Outpatient Hospital	$90 copay per visit after deductible is met	Not covered
X-Ray		
Office	$90 copay per visit deductible does not apply‡	Not covered
Freestanding Radiology Center	$90 copay per visit 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
Outpatient Hospital	$90 copay per visit after deductible is met	Not covered
Advanced Diagnostic Imaging *for example: MRI, PET and CAT scans*		
Office	$300 copay per visit deductible does not apply	Not covered
Freestanding Radiology Center	$250 copay per visit deductible does not apply	Not covered
Outpatient Hospital	$500 copay per visit 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.*	$90 copay per visit deductible does not apply	Covered as In-Network
Emergency Room Facility Services	$1,000 copay per visit 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.*	No charge after deductible is met	Covered as In-Network
Ambulance	$1,000 copay per trip after deductible is met	Covered as In-Network
Outpatient Mental Health and Substance Use Disorder Services at a Facility		
Facility Fees	$500 copay per visit deductible does not apply	Not covered
Doctor Services	No charge	Not covered
Outpatient Surgery		
Facility Fees		
Hospital	$1,000 copay per procedure 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
Ambulatory Surgical Center	$500 copay per visit deductible does not apply	Not covered
Physician and other services *including surgeon fees*		
Hospital	No charge after deductible is met	Not covered
Ambulatory Surgical Center	No charge	Not covered
Hospital (Including Maternity, Mental Health and Substance Use Disorder Services) *If readmitted within 72 hours for the same condition, no additional facility copay is required. If transferred between facilities, only one copay will apply.*		
Facility Fees	$1,500 copay per admission after deductible is met	Not covered
Physician and other services *including surgeon fees*	No charge 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.*	$90 copay per visit deductible does not apply	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	$30 copay per visit deductible does not apply	Not covered
Outpatient Hospital	$90 copay per visit after deductible is met	Not covered
Pulmonary rehabilitation		
Office	$90 copay per visit deductible does not apply	Not covered
Outpatient Hospital	$90 copay per visit 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
Cardiac rehabilitation *Coverage is limited to 36 visits per benefit period.*		
Office	$90 copay per visit deductible does not apply	Not covered
Outpatient Hospital	$90 copay per visit after deductible is met	Not covered
Dialysis/Hemodialysis		
Office	$90 copay per visit deductible does not apply	Not covered
Outpatient Hospital	$1,000 copay per visit after deductible is met	Not covered
Chemo/Radiation Therapy		
Office	$90 copay per visit deductible does not apply	Not covered
Outpatient Hospital	$1,000 copay per visit 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.*	$1,500 copay per admission after deductible is met	Not covered
Inpatient Hospice	$1,500 copay per admission after deductible is met	Not covered
Durable Medical Equipment	30% 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.*	30% 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	Combined with In-Network medical deductible (does not apply to Tier 1a, Tier 1b, Tier 2 drugs)	Combined with In-Network medical deductible (does not apply to Tier 1a, Tier 1b, Tier 2 drugs)	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 1a - Typically Lower Cost Generic	No charge (retail and home delivery)	$10 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 1b - Typically Generic	$10 copay per prescription, deductible does not apply (retail) and $25 copay per prescription, deductible does not apply (home delivery)	$20 copay per prescription, deductible does not apply (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 2 – Typically Preferred Brand	$60 copay per prescription, deductible does not apply (retail) and $180 copay per prescription, deductible does not apply (home delivery)	$70 copay per prescription, deductible does not apply (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
Tier 3 - Typically Non-Preferred Brand	$125 copay per prescription after deductible is met (retail) and $375 copay per prescription after deductible is met (home delivery)	$135 copay per prescription after deductible is met (retail) and Not covered (home delivery)	Not covered (retail and home delivery)
Tier 4 - Typically Specialty (brand and generic)	$400 copay per prescription after deductible is met (retail and home delivery)	$500 copay per prescription after deductible is met (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.
- ‡ You will pay the PCP's office visit copay when services are provided in their office.

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

Your summary of benefits

Anthem

Your Plan: Anthem Link Pathway HMO 6000/$30/$90/8500 Rx $0/$10/$60/$125/$400 Ded T3/T3 Essential Tiered Rx
Your Network: Pathway - HMO

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:

Chinese(中文)：如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(877) 811-3106。

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (877) 811-3106 تماس بگیرید.

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (877) 811-3106.

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.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (877) 811-3106.

Japanese (日本語):この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。 通訳と話すには、(877) 811-3106 にお電話ください。

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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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Russian (Русский): если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (877) 811-3106.

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Vietnamese (Tiếng Việt): Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (877) 811-3106.

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.