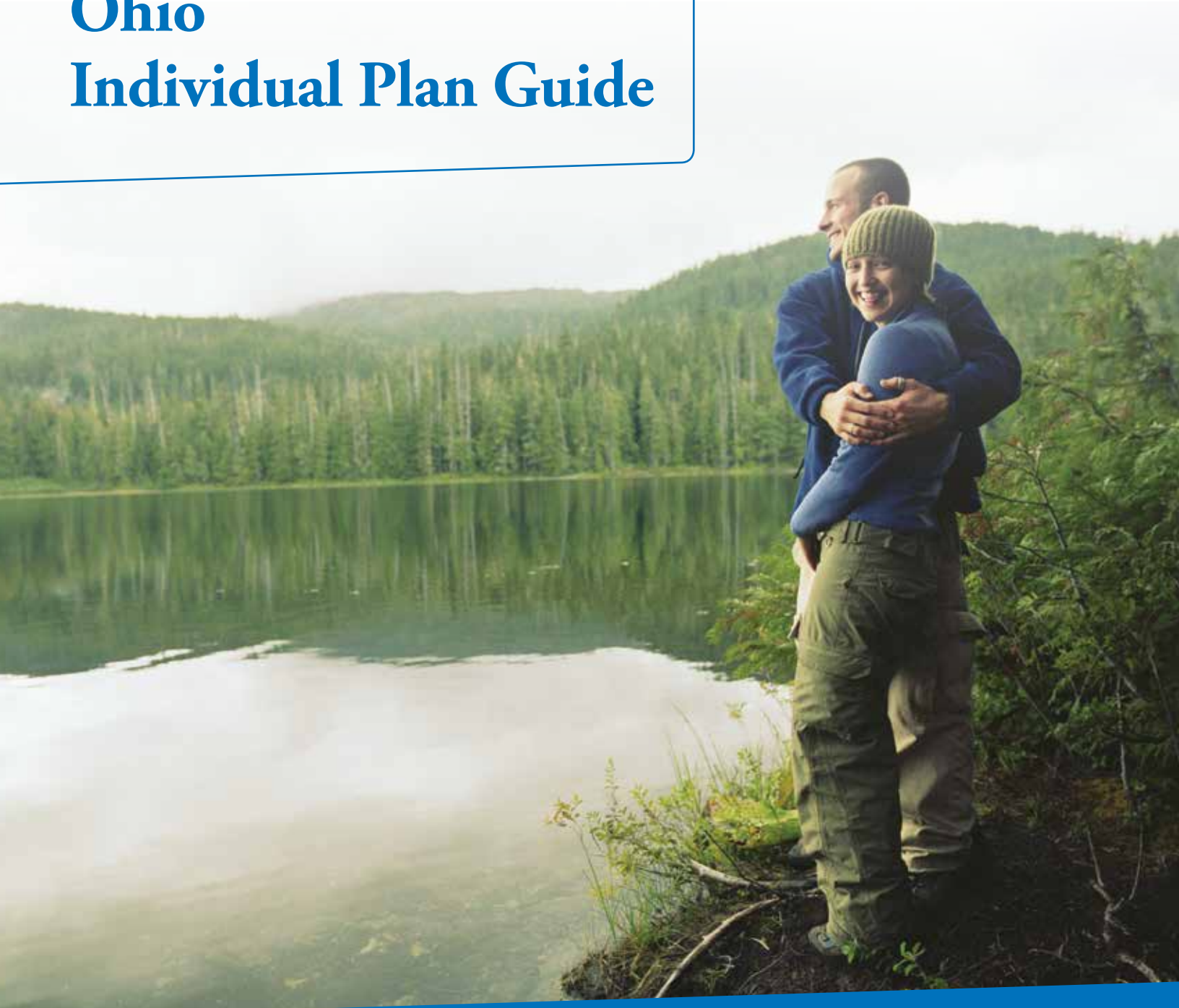


Effective January 1, 2016

Ohio Individual Plan Guide



Plans that offer choices — and meet
Affordable Care Act (ACA) requirements



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Here are the **tools and support to help you succeed**

Access to the latest range of plans

Built from the ground up — with the strengths you've come to expect from the Anthem product portfolio

We're here to help you understand Anthem plans and offer any support you may need. This guide is one important way we do that because it quickly gives you a clear picture of what's offered.

Inside this guide you'll find answers to many common questions about:

- Changes to look for in 2016, such as the addition of our new HMO plans and network.
- 2016 plans and features, including medical, pharmacy and specialty.
- The latest on our health and wellness offerings and much more.

All 2016 plans in our portfolio are ACA-compliant and cover services from preventive care to emergencies and more. They include:

- Preventive, wellness and long-term disease management services
- Outpatient (ambulatory) care
- Emergency services, including emergency room or urgent care
- Inpatient care (hospital stays)
- Laboratory services
- Prescription drugs
- Mental health and substance abuse
- Maternity (pregnancy) and newborn care
- Pediatric vision
- Pediatric dental
- Rehabilitative and habilitative services

Boost your earnings potential with tools and support that help make it easy to quote and sell.

Here are just a few of the many reasons why selling Anthem makes sense for your business:

- Online quoting tools let you easily run quotes and get them to your clients.
- Online applications are simple for clients to fill out and when you send your AgentConnect link, your broker information is attached to the application.
- Producer Toolbox keeps all the tools you need right at your fingertips.
- Dedicated sales team knows the market — and they're focused on you.

It's time to expect more of health care plans.

Anthem is right there with you.

Your clients want the best value their health care dollars can buy. And in Ohio, we deliver like no one else — through our networks and our experience.



31,617
PHYSICIANS*



450
HOSPITALS*



76 years
OF SERVICE*

*Based on Internal Provider Data Report, 2015. Physicians includes Medical Doctors and Doctors of Osteopathic Medicine. Hospitals includes General Acute Care Hospitals, Surgical Services (Ambulatory Surgical Centers and Outpatient Hospitals) & Inpatient Psychiatry (Free-standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital).

Changes to look for in 2016

- Embedded health savings account (HSA) deductibles
- Modified names if necessary (change in deductible, plan type, state request)
- Added \$50,000 per occurrence limit on non-network, non-emergency ambulance on plans with non-network benefits
- Added Pathway X HMO and Pathway HMO in 25 counties in Ohio for both on and off the exchange, and utilized by eight new HMO plans.
- Added one new Bronze PPO plan on and off the exchange

Why Anthem?


Health plans don't have to be complicated.


We understand that every one of your clients is unique. That's why we offer many high-quality, affordable plan options to help clients be their healthy best and still keep plan costs down.


With Anthem, you can count on:

- A strong network
- Competitive pricing
- A brand you can trust
- Resources and support for your clients' health care goals
- Convenient online tools
- A simple enrollment process
- Dedicated customer service
- Coordinated care that connects your clients' doctors and health care providers

Built-in benefits that make a difference

 **24/7 NurseLine** — Day or night, your clients can talk to a registered nurse about their health concerns or help with specific questions about a condition they are managing (like asthma or diabetes) through our 24/7 NurseLine. Whether it's a question about allergies, the flu or choosing between the ER or urgent care, our nurses are always there for your clients.


 **BlueCard®** — Our PPO plans include coverage for non-emergency care in all states through the Blue Cross and Blue Shield Association's BlueCard Program. Your clients and their covered families can have full coverage from coast to coast.


 **ConditionCare** — The health of your clients is our top priority. If they have an ongoing or complex health problem, a case manager may call them to see how we can help manage their condition and give your clients information and emotional support services.


If your clients need extra support in managing their health or a certain health condition (like asthma or diabetes), the preventive services offered in their plan are covered at 100% and can help improve their health and well-being.


These are just some of the routine preventive services we are pleased to offer your clients:


- Routine primary care physician office visits to help them discuss their condition
- Lab tests that ensure they are on their wellness path
- Preventive prescription medicines
- Blood tests to measure cholesterol, triglycerides, and lipoproteins (HDL and LDL)
- Health screenings like routine ECG, ultrasound and more
- Comprehensive metabolic panels to measure sugar (glucose) level, electrolyte and fluid balance, as well as kidney and liver function

 **Estimate Your Cost** — Out-of-pocket cost calculator helps your clients know their costs before having certain tests or treatments.

 **Find a Doctor** — Find in-network doctors using this tool on anthem.com. It's ready even before someone enrolls.

 **MyHealth Advantage** — Checks your clients' health care and pharmacy records to find ways to help them live a healthier life and save money. When we find ways to do this, your clients get a MyHealth Note in the mail.

 **Pharmacy on-the-go** — Helps your clients easily find a pharmacy, find out what a drug costs, switch from retail to home delivery, order a refill, check order status and more.

 **SpecialOffers@AnthemSM** discounts— Members-only savings on vitamins, health and beauty products, chiropractic care, acupuncture, massage therapy, LASIK eye surgery, eyeglass frames and contact lenses, hearing aids and services, fitness center memberships, Jenny Craig® and Weight Watchers® weight-loss programs and more. To view all discounts, your clients just need to log into anthem.com and select **Discounts** located on the *Main Overview* page.

Online tools to help clients make informed choices

From our website and mobile app to cost and quality comparison tools, we want to make sure that your clients have the information they need to make the best health care decisions for them.

With our secure website, your clients can:

- Get a breakdown of what is and isn't covered through a benefit summary.
- See their recent claims and coverage details.
- Estimate their costs before having certain procedures.

With our mobile app, your clients can:

- Search for a nearby doctor, specialist, urgent care center or hospital.
- Get turn-by-turn directions to get there.
- Manage their prescription drug benefits, including pricing medications, switching from retail to home delivery and ordering refills.
- Carry a virtual member ID card.

Cost and quality information with Estimate Your Cost

With our Estimate Your Cost tool, your clients can save time and money by comparing the cost of common procedures at health care facilities in their area. They'll also get to see the quality and safety ratings for those facilities.

LiveHealth Online offers 24/7 access to care

LiveHealth Online¹ is a convenient way for your clients to talk face-to-face with a board-certified doctor when their own doctor isn't available.² Your clients can access medical care using their computer or mobile device when they need it, 24/7. All they have to do is sign up at livehealthonline.com or download the app.

Once they become a member and register with LiveHealth Online, they can:

- Get medical advice, diagnoses, proper treatment and even prescriptions,³ as needed.
- Quickly address common health problems, like allergies, colds, rashes, fever and more.
- See a doctor via video chat without the wait.

LiveHealth Online visits cost \$49 or less depending on the health plan. The tool is currently only available in English.

¹ LiveHealth Online is the trade name of the Health Management Corporation.

² LiveHealth Online is offered in most states and is expected to expand into more areas in the near future. Visit the home page at livehealthonline.com to see the latest map showing where service is available.

³ This is legally permitted only in certain states.

Enhanced Personal Health Care

Enhanced Personal Health Care is a new kind of doctor-patient relationship created just for Anthem members!

Through this program, we're putting patients in a unique circle of care, making them the central focus of a team approach to their overall health. We do this by:

- Improving your client's patient experience with better access to a primary care physician (PCP) who cares for the "whole person" and becomes their health care champion and helps them navigate the health care system.
- Giving doctors added support with the right tools and strategies to help strengthen your client's doctor-patient relationship so doctors can spend more time with patients and coordinate their care with other doctors.

Travel coverage for peace of mind

Your clients can access care no matter where they are in the U.S. or worldwide.

Whether they're traveling for work or on vacation, going to the emergency room (ER) or urgent care is probably the last thing your clients want to worry about. The good news is that our HMO and PPO plans cover emergency and urgent care in all 50 states.

With the Blue Cross and Blue Shield Association's BlueCard® program, our preferred provider organization (PPO) plans also include extra coverage for non-emergency care when they visit participating BlueCard providers in the U.S. or travel abroad. They can see any provider they wish, but they'll pay less out of pocket when they use BlueCard providers and hospitals.

Register at anthem.com for online access

Once your clients become members, they can register at **anthem.com** to access benefits online. They just choose **Register Now** on the top right-hand side of the home page.

Our network

Our network includes:

- Doctors, therapists, mental health providers and other health care professionals
- Hospitals and outpatient facilities
- Pharmacies
- ERs and urgent care centers
- Labs and radiology centers
- Durable medical equipment, including hospital beds, crutches, wheelchairs and oxygen tanks (retail and online stores)

Network details: PPO and HMO

We will have both Pathway X/Pathway Tiered Hospital network (PPO) and Pathway X HMO/Pathway HMO network in 2016. Depending on what type of plan your clients choose, their benefits and provider choices may be different:

PPO: With a PPO, your clients will be able to see any provider they want without a referral because no primary care doctor gatekeepers are required. Also, PPOs provide coverage for both network and non-network providers — though your clients save when they stay in the network.

HMO: With our HMO, your clients don't have to choose a PCP to manage their care needs — including getting referrals to see other doctors. Having your client select a primary care doctor is still a good idea for things like checkups and any ongoing health issues. HMOs don't offer non-network benefits, except for emergency and urgent care or when a service is preauthorized. If your clients go outside the network for any other reason, they'll have to pay 100% out of pocket.

Tiered hospitals: Our Pathway X Tiered Hospitals/Pathway Tiered Hospital (PPO) networks include tiered hospitals. Hospitals in those networks are split into two categories: Tier 1 and Tier 2. Your clients pay a lower cost share for hospitals in Tier 1. Plans using tiered hospitals will have "tiered" in the network name.

Which providers are in the network?

To check, your clients can use our *Find a Doctor* tool on anthem.com. They'll be able to see whether their current doctor is in the network or find a new doctor who is. The tool can also help them look for in-network specialists, hospitals (Tier 1 and Tier 2), urgent care centers and pharmacies in their area. When using the tool, they need to include the plan network Pathway/Pathway X Tiered Hospital Network (PPO) or Pathway HMO/Pathway X HMO, in their search criteria for the plan they're considering. Network availability may depend on where they live.¹

For searches on the go, your clients can download our Anthem mobile app to their mobile device and use the *Find a Doctor* app feature.

¹ Pathway X HMO/Pathway HMO is only available in 25 counties in Ohio. The Pathway/Pathway X Tiered Hospital (PPO) network is available state-wide across Ohio.

Off-exchange plans

	Anthem Bronze Pathway HMO 5000/40% (1X2F) ¹	Anthem Bronze Pathway HMO 5200/20% (1X2J) ¹	Anthem Bronze Pathway HMO 6850/0% (1X2M) ¹
Network name ¹	Pathway HMO	Pathway HMO	Pathway HMO
Plan includes non-network coverage?	No	No	No
Coverage	Network	Network	Network
Individual deductible ² (Family ³ = 2 x individual amount)	\$5,000	\$5,200	\$6,850
How family deductibles work	Embedded	Embedded	Embedded
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$6,850	\$6,850
Coinsurance ²	40% coinsurance	20% coinsurance	0% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$50 copay per visit for first 2 office visits, then deductible and 40% coinsurance	\$35 copay per visit for first 2 office visits, then deductible and 20% coinsurance	Deductible, then 0% coinsurance
Office visit: specialist*	Deductible, then 40% coinsurance	\$70 copay per visit for first 2 office visits, then deductible and 20% coinsurance	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 40% coinsurance	Deductible, then \$200 and 20% coinsurance	Deductible, then 0% coinsurance
Preventive care ⁴	No additional cost	No additional cost	No additional cost
Urgent care	Deductible, then \$50 copay and 40% coinsurance	Deductible, then \$50 copay and 20% coinsurance	Deductible, then 0% coinsurance
Emergency room care	Deductible, then \$200 copay and 40% coinsurance	Deductible, then \$500 copay and 20% coinsurance	Deductible, then 0% coinsurance
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 40% coinsurance	Deductible, then \$500 copay and 20% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$500 copay and 40% coinsurance	Deductible, then \$500 copay and 20% coinsurance	Deductible, then 0% coinsurance
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Medical deductible applies	Medical deductible applies	Medical deductible applies
Retail pharmacy tier 1 ⁶	40% coinsurance	20% coinsurance	0% coinsurance
Retail pharmacy tier 2 ⁶	40% coinsurance	20% coinsurance	0% coinsurance
Retail pharmacy tier 3 ⁶	40% coinsurance	20% coinsurance	0% coinsurance
Retail pharmacy tier 4 ⁶	40% coinsurance	20% coinsurance	0% coinsurance
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered
Mental health and substance abuse: outpatient facility and services	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$500 copay and 40% coinsurance	Deductible, then \$500 copay and 20% coinsurance	Deductible, then 0% coinsurance
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

Off-exchange plans

	Anthem Bronze Pathway PPO 5000/25% (1GKW)		Anthem Bronze Pathway PPO 5000/30% (1GKZ)		Anthem Bronze Pathway PPO 5550/20% (1GL5)	
Network name ¹	Pathway Tiered Hospital PPO		Pathway Tiered Hospital PPO		Pathway Tiered Hospital PPO	
Plan includes non-network coverage?	Yes		Yes		Yes	
Coverage	Network	Non-network	Network	Non-network	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$5,000	\$15,000	\$5,000	\$15,000	\$5,550	\$16,650
How family deductibles work	Embedded		Embedded		Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$20,550	\$6,850	\$20,550	\$6,850	\$20,550
Coinsurance ²	25% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$45 copay per visit for first 2 office visits, then deductible and 25% coinsurance		\$55 copay per visit for first 2 office visits, then deductible and 30% coinsurance		Deductible, then 20% coinsurance	
Office visit: specialist*	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	
Preventive care ⁴	No additional cost		No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 25% coinsurance		Deductible, then \$50 copay and 30% coinsurance		Deductible, then \$50 copay and 20% coinsurance	
Emergency room care	Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$350 copay and 30% coinsurance		Deductible, then \$500 copay and 20% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then 25% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then \$500 copay and 30% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then 20% (tier 1)/ 50% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then 25% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then \$500 copay and 30% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then 20% (tier 1)/ 50% (tier 2) coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Medical deductible applies		Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	
Retail pharmacy tier 1 ⁶	25% coinsurance		30% coinsurance		\$30 copay	
Retail pharmacy tier 2 ⁶	25% coinsurance		30% coinsurance		\$75 copay	
Retail pharmacy tier 3 ⁶	25% coinsurance		30% coinsurance		20% coinsurance	
Retail pharmacy tier 4 ⁶	25% coinsurance		30% coinsurance		20% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then 25% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then \$500 copay and 30% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then 20% (tier 1)/ 50% (tier 2) coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

Off-exchange plans

	Anthem Bronze Pathway PPO 5850/35% (1WZQ)		Anthem Bronze Pathway PPO 6500/20% (1GL2)		Anthem Bronze Pathway PPO 0% for HSA (1GKT)	
Network name ¹	Pathway Tiered Hospital PPO		Pathway Tiered Hospital PPO		Pathway Tiered Hospital PPO	
Plan includes non-network coverage?	Yes		Yes		Yes	
Coverage	Network	Non-network	Network	Non-network	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$5,850	\$17,550	\$6,500	\$19,500	\$6,550	\$19,650
How family deductibles work	Embedded		Embedded		Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$20,550	\$6,850	\$20,550	\$6,550	\$19,650
Coinsurance ²	35% coinsurance	55% coinsurance	20% coinsurance	50% coinsurance	0% coinsurance	30% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	Deductible, then 35% coinsurance		\$60 copay per visit for first 2 office visits, then deductible and 20% coinsurance		Deductible, then 0% coinsurance	
Office visit: specialist*	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	
Preventive care ⁴	No additional cost		No additional cost		No additional cost	
Urgent care	Deductible, then \$75 copay and 35% coinsurance		Deductible, then \$50 copay and 20% coinsurance		Deductible, then 0% coinsurance	
Emergency room care	Deductible, then \$500 copay and 35% coinsurance		Deductible, then \$300 copay and 20% coinsurance		Deductible, then 0% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$1,000 copay and 0% coinsurance (tier 1)/\$750 copay and 55% coinsurance (tier 2)		Deductible, then 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then 0% (tier 1)/30% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$1,000 copay and 0% coinsurance (tier 1)/\$750 copay and 55% coinsurance (tier 2)		Deductible, then 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then 0% (tier 1)/30% (tier 2) coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Medical deductible applies	
Retail pharmacy tier 1 ⁶	35% coinsurance		\$30 copay		0% coinsurance	
Retail pharmacy tier 2 ⁶	35% coinsurance		\$75 copay		0% coinsurance	
Retail pharmacy tier 3 ⁶	35% coinsurance		20% coinsurance		0% coinsurance	
Retail pharmacy tier 4 ⁶	35% coinsurance		20% coinsurance		0% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$1,000 copay and 0% coinsurance (tier 1)/\$750 copay and 55% coinsurance (tier 2)		Deductible, then 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then 0% (tier 1)/30% (tier 2) coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

Off-exchange plans

	Anthem Silver Pathway HMO 2850/15% (1X35) ¹	Anthem Silver Pathway HMO 3000/10% (1X2Z) ¹	Anthem Silver Pathway HMO 4250/30% (1X2T) ¹
Network name ¹	Pathway HMO	Pathway HMO	Pathway HMO
Plan includes non-network coverage?	No	No	No
Coverage	Network	Network	Network
Individual deductible ² (Family ³ = 2 x individual amount)	\$2,850	\$3,000	\$4,250
How family deductibles work	Embedded	Embedded	Embedded
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$6,850	\$5,250
Coinsurance ²	15% coinsurance	10% coinsurance	30% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$30 copay per office visit, unlimited	\$40 copay per visit for first 3 office visits, then deductible and 10% coinsurance	\$25 copay per office visit, unlimited
Office visit: specialist*	Deductible, then 15% coinsurance	\$75 copay per visit for first 3 office visits, then deductible and 10% coinsurance	\$50 copay per office visit, unlimited
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 15% coinsurance	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then \$300 copay and 15% coinsurance	Deductible, then \$200 copay and 10% coinsurance	Deductible, then 30% coinsurance
Preventive care ⁴	No additional cost	No additional cost	No additional cost
Urgent care	Deductible, then \$50 copay and 15% coinsurance	Deductible, then \$50 copay and 10% coinsurance	\$90 copay
Emergency room care	Deductible, then \$500 copay and 15% coinsurance	Deductible, then \$500 copay and 10% coinsurance	Deductible, then 30% coinsurance
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 15% coinsurance	Deductible, then \$500 copay and 10% coinsurance	Deductible, then \$500 copay and 30% coinsurance
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 15% coinsurance	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$500 copay and 15% coinsurance	Deductible, then \$500 copay and 10% coinsurance	Deductible, then \$500 copay and 30% coinsurance
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tier 1: No deductible Tiers 2, 3, 4: \$1,000 Pharmacy deductible
Retail pharmacy tier 1 ⁶	\$20 copay	\$15 copay	\$15 copay
Retail pharmacy tier 2 ⁶	\$50 copay	\$40 copay	\$40 copay
Retail pharmacy tier 3 ⁶	15% coinsurance	10% coinsurance	50% coinsurance
Retail pharmacy tier 4 ⁶	15% coinsurance	10% coinsurance	50% coinsurance
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered
Mental health and substance abuse: outpatient facility and services	Deductible, then 15% coinsurance	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$500 copay and 15% coinsurance	Deductible, then \$500 copay and 10% coinsurance	Deductible, then \$500 copay and 30% coinsurance
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 15% coinsurance	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 15% coinsurance	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

Off-exchange plans

	Anthem Silver Pathway PPO 2200/15% (1GMF)		Anthem Silver Pathway PPO 2000/20% (1GLV)		Anthem Silver Pathway PPO 2500/10% (1GM1)	
Network name ¹	Pathway Tiered Hospital		Pathway Tiered Hospital		Pathway Tiered Hospital	
Plan includes non-network coverage?	Yes		Yes		Yes	
Coverage	Network	Non-network	Network	Non-network	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$2,200	\$6,600	\$2,000	\$6,000	\$2,500	\$7,500
How family deductibles work	Embedded		Embedded		Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$20,550	\$6,850	\$20,550	\$6,850	\$20,550
Coinsurance ²	15% coinsurance	45% coinsurance	20% coinsurance	50% coinsurance	10% coinsurance	40% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	Deductible, then 15% coinsurance		\$45 copay per visit for first 2 office visits, then deductible and 20% coinsurance		\$45 copay per office visit, unlimited	
Office visit: specialist*	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	
Preventive care ⁴	No additional cost		No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 15% coinsurance		Deductible, then \$50 copay and 20% coinsurance		Deductible, then \$50 copay and 10% coinsurance	
Emergency room care	Deductible, then \$350 copay and 15% coinsurance		Deductible, then \$350 copay and 20% coinsurance		Deductible, then \$350 copay and 10% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 15% (tier 1)/ 45% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$500 copay and 15% (tier 1)/ 45% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	
Retail pharmacy tier 1 ⁶	\$15 copay		\$15 copay		\$20 copay	
Retail pharmacy tier 2 ⁶	\$40 copay		\$45 copay		\$50 copay	
Retail pharmacy tier 3 ⁶	15% coinsurance		20% coinsurance		10% coinsurance	
Retail pharmacy tier 4 ⁶	15% coinsurance		20% coinsurance		10% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$500 copay and 15% (tier 1)/ 45% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

Off-exchange plans

	Anthem Silver Pathway PPO 3000/10% (1GLB)		Anthem Silver Pathway PPO 3750/0% (1GLP)	
Network name ¹	Pathway Tiered Hospital		Pathway Tiered Hospital	
Plan includes non-network coverage?	Yes		Yes	
Coverage	Network	Non-network	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$3,000	\$9,000	\$3,750	\$11,250
How family deductibles work	Embedded		Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,000	\$18,000	\$6,500	\$19,500
Coinsurance ²	10% coinsurance	40% coinsurance	0% coinsurance	30% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$40 copay per visit for first 3 office visits, then deductible and 10% coinsurance		\$45 copay per office visit, unlimited	
Office visit: specialist*	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	
Preventive care ⁴	No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 10% coinsurance		Deductible, then \$50 copay and 0% coinsurance	
Emergency room care	Deductible, then \$200 copay and 10% coinsurance		Deductible, then \$200 copay and 0% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/ 30% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/ 30% (tier 2) coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	
Retail pharmacy tier 1 ⁶	10% coinsurance		\$15 copay	
Retail pharmacy tier 2 ⁶	10% coinsurance		\$40 copay	
Retail pharmacy tier 3 ⁶	10% coinsurance		0% coinsurance	
Retail pharmacy tier 4 ⁶	10% coinsurance		0% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/ 30% (tier 2) coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

Off-exchange plans

	Anthem Silver Pathway PPO 3500/25% (1GM9)		Anthem Silver Pathway PPO 10% for HSA (1GLH)	
Network name ¹	Pathway Tiered Hospital		Pathway Tiered Hospital	
Plan includes non-network coverage?	Yes		Yes	
Coverage	Network	Non-network	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$3,500	\$10,500	\$2,600	\$7,800
How family deductibles work	Embedded		Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$5,500	\$16,500	\$5,000	\$15,000
Coinsurance ²	25% coinsurance	50% coinsurance	10% coinsurance	40% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$20 copay per office visit, unlimited		Deductible, then 10% coinsurance	
Office visit: specialist*	\$60 copay per office visit, unlimited		Deductible, then 10% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 25% coinsurance		Deductible, then 10% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 25% coinsurance		Deductible, then 10% coinsurance	
Preventive care ⁴	No additional cost		No additional cost	
Urgent care	\$90 copay		Deductible, then \$50 copay and 10% coinsurance	
Emergency room care	Deductible, then 25% coinsurance		Deductible, then \$200 copay and 10% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 10%(tier 1)/ 40% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 25% coinsurance		Deductible, then 10% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1: No deductible Tiers 2, 3, 4: \$1,000 Combined pharmacy deductible		Medical deductible applies	
Retail pharmacy tier 1 ⁶	\$10 copay		10% coinsurance	
Retail pharmacy tier 2 ⁶	\$40 copay		10% coinsurance	
Retail pharmacy tier 3 ⁶	40% coinsurance		10% coinsurance	
Retail pharmacy tier 4 ⁶	40% coinsurance		10% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 25% coinsurance		Deductible, then 10% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 25% coinsurance		Deductible, then 10% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 25% coinsurance		Deductible, then 10% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

Off-exchange plans

	Anthem Gold Pathway HMO 1150/10% (1X38) ¹	Anthem Gold Pathway HMO 1450/20% (1X38) ¹	Anthem Gold Pathway PPO 1250/10% (1GM4)	
Network name ¹	Pathway HMO		Pathway Tiered Hospital	
Plan includes non-network coverage?	No		Yes	
Coverage	Network	Network	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$1,150	\$1,450	\$1,250	\$3,750
How family deductibles work	Embedded		Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$4,900	\$3,100	\$5,000	\$15,000
Coinsurance ²	10% coinsurance	20% coinsurance	10% coinsurance	40% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$30 copay per office visit, unlimited		\$30 copay per office visit, unlimited	
Office visit: specialist*	\$60 copay per office visit, unlimited		\$75 copay per office visit, unlimited	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Preventive care ⁴	No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 10% coinsurance		\$90 copay	
Emergency room care	Deductible, then \$500 copay and 10% coinsurance		Deductible, then 20% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 10% coinsurance		Deductible, then \$500 copay and 20% coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 10% coinsurance		Deductible, then 20% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$500 copay and 10% coinsurance		Deductible, then \$500 copay and 20% coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tier 1: No deductible Tiers 2, 3, 4: \$600 Combined pharmacy deductible	
Retail pharmacy tier 1 ⁶	\$15 copay		\$10 copay	
Retail pharmacy tier 2 ⁶	\$40 copay		\$35 copay	
Retail pharmacy tier 3 ⁶	10% coinsurance		40% coinsurance	
Retail pharmacy tier 4 ⁶	10% coinsurance		40% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 10% coinsurance		Deductible, then 20% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$500 copay and 10% coinsurance		Deductible, then \$500 copay and 20% coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 10% coinsurance		Deductible, then 20% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 10% coinsurance		Deductible, then 20% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

Off-exchange plans

	Anthem Catastrophic Pathway PPO 6850/0% (1GKQ)	
Network name ¹	Pathway Tiered Hospital	
Plan includes non-network coverage?	Yes	
Coverage	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$6,850	\$20,550
How family deductibles work	Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$20,550
Coinsurance ²	0% coinsurance	30% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$40 copay per visit for first 3 office visits, then deductible and 0% coinsurance	
Office visit: specialist*	Deductible, then 0% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 0% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 0% coinsurance	
Preventive care ⁴	No additional cost	
Urgent care	Deductible, then 0% coinsurance	
Emergency room care	Deductible, then 0% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then 0% coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 0% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then 0% coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Medical deductible applies	
Retail pharmacy tier 1 ⁶	0% coinsurance	
Retail pharmacy tier 2 ⁶	0% coinsurance	
Retail pharmacy tier 3 ⁶	0% coinsurance	
Retail pharmacy tier 4 ⁶	0% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 0% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then 0% coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 0% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 0% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

1 Tiered hospitals: Our PPO plans offer a tiered network. Network hospitals are split into two categories, Tier 1 and Tier 2. Your clients pay a lower cost share for hospitals in Tier 1. To see what tier a hospital is in, visit the Find a Doctor tool at anthem.com.

2 PPO plans also include non-network benefits. Our HMO plans only include non-network benefits for emergency care, urgent care and ambulance services.

3 Individual deductible, individual out-of-pocket limit and coinsurance reflect network/non-network cost share information, if applicable for the plan. All other cost share information is for network services only.

4 LiveHealth Online web visits have the same PCP office visit cost share listed in the chart.

5 For plans with PCP and specialist office visit limits, the visit limits are combined, not separate.

6 Cost share shows Tier 1/Tier 2 coinsurance for hospitals in our network.

7 For plans with a retail pharmacy deductible, the pharmacy deductible is separate from the medical deductible. The family deductible is 2 x the individual amount.

8 Pediatric dental is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

On-exchange plans

	Anthem Bronze Pathway X HMO 5000/40% (1X2D) ¹	Anthem Bronze Pathway X HMO 5200/20% (1X2G) ¹	Anthem Bronze Pathway X HMO 6850/0% (1X2K) ¹
Network name ¹	Pathway X HMO	Pathway X HMO	Pathway X HMO
Plan includes non-network coverage?	No	No	No
Coverage	Network	Network	Network
Individual deductible ² (Family ³ = 2 x individual amount)	\$5,000	\$5,200	\$6,850
How family deductibles work	Embedded	Embedded	Embedded
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$6,850	\$6,850
Coinsurance ²	40% coinsurance	20% coinsurance	0% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$50 copay per visit for first 2 office visits, then deductible and 40% coinsurance	\$35 copay per visit for first 2 office visits, then deductible and 20% coinsurance	Deductible, then 0% coinsurance
Office visit: specialist*	Deductible, then 40% coinsurance	\$70 copay per visit for first 2 office visits, then deductible and 20% coinsurance	Deductible, then 0% coinsurance
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Preventive care ⁴	No additional cost	No additional cost	No additional cost
Urgent care	Deductible, then \$50 copay and 40% coinsurance	Deductible, then \$50 copay and 20% coinsurance	Deductible, then 0% coinsurance
Emergency room care	Deductible, then \$200 copay and 40% coinsurance	Deductible, then \$200 copay and 20% coinsurance	Deductible, then 0% coinsurance
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 40% coinsurance	Deductible, then \$500 copay and 20% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$500 copay and 40% coinsurance	Deductible, then \$500 copay and 20% coinsurance	Deductible, then 0% coinsurance
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Medical deductible applies	Medical deductible applies	Medical deductible applies
Retail pharmacy tier 1 ⁶	40% coinsurance	20% coinsurance	0% coinsurance
Retail pharmacy tier 2 ⁶	40% coinsurance	20% coinsurance	0% coinsurance
Retail pharmacy tier 3 ⁶	40% coinsurance	20% coinsurance	0% coinsurance
Retail pharmacy tier 4 ⁶	40% coinsurance	20% coinsurance	0% coinsurance
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered
Mental health and substance abuse: outpatient facility and services	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$500 copay and 40% coinsurance	Deductible, then \$500 copay and 20% coinsurance	Deductible, then 0% coinsurance
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 40% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

On-exchange plans

	Anthem Bronze Pathway X PPO 5000/25% (1GKU)		Anthem Bronze Pathway X PPO 5000/30% (1GKY)		Anthem Bronze Pathway X PPO 5550/20% (1GL3)	
Network name ¹	Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital	
Plan includes non-network coverage?	Yes		Yes		Yes	
Coverage	Network	Non-network	Network	Non-network	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$5,000	\$15,000	\$5,000	\$15,000	\$5,550	\$16,650
How family deductibles work	Embedded		Embedded		Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$20,550	\$6,850	\$20,550	\$6,850	\$20,550
Coinsurance ²	25% coinsurance	50% coinsurance	30% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$45 copay per visit for first 2 office visits, then deductible and 25% coinsurance		\$55 copay per visit for first 2 office visits, then deductible and 30% coinsurance		Deductible, then 20% coinsurance	
Office visit: specialist*	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	
Preventive care ⁴	No additional cost		No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 25% coinsurance		Deductible, then \$50 copay and 30% coinsurance		Deductible, then \$50 copay and 20% coinsurance	
Emergency room care	Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$350 copay and 30% coinsurance		Deductible, then \$500 copay and 20% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then 25% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then \$500 copay and 30% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then 20% (tier 1)/ 50% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then 25% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then \$500 copay and 30% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then 20% (tier 1)/ 50% (tier 2) coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Medical deductible applies		Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	
Retail pharmacy tier 1 ⁶	25% coinsurance		30% coinsurance		\$30 copay	
Retail pharmacy tier 2 ⁶	25% coinsurance		30% coinsurance		75/copay	
Retail pharmacy tier 3 ⁶	25% coinsurance		30% coinsurance		20% coinsurance	
Retail pharmacy tier 4 ⁶	25% coinsurance		30% coinsurance		20% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then 25% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then \$500 copay and 30% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then 20% (tier 1)/ 50% (tier 2) coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 25% coinsurance		Deductible, then 30% coinsurance		Deductible, then 20% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

On-exchange plans

	Anthem Bronze Pathway X PPO 5850/35% (1WZN)		Anthem Bronze Pathway X PPO 6500/20% (1GLO)		Anthem Bronze Pathway X PPO 0% for HSA (1GKR)	
Network name ¹	Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital	
Plan includes non-network coverage?	Yes		Yes		Yes	
Coverage	Network	Non-network	Network	Non-network	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$5,850	\$17,550	\$6,500	\$19,500	\$6,550	\$19,650
How family deductibles work	Embedded		Embedded		Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$20,550	\$6,850	\$20,550	\$6,550	\$19,650
Coinsurance ²	35% coinsurance	55% coinsurance	20% coinsurance	50% coinsurance	0% coinsurance	30% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	Deductible, then 35% coinsurance		\$60 copay per visit for first 2 office visits, then deductible and 20% coinsurance		Deductible, then 0% coinsurance	
Office visit: specialist*	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	
Preventive care ⁴	No additional cost		No additional cost		No additional cost	
Urgent care	Deductible, then \$75 copay and 35% coinsurance		Deductible, then \$50 copay and 20% coinsurance		Deductible, then 0% coinsurance	
Emergency room care	Deductible, then \$500 copay and 35% coinsurance		Deductible, then \$300 copay and 20% coinsurance		Deductible, then 0% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$1,000 copay and 0% coinsurance (tier 1)/\$750 copay and 55% coinsurance (tier 2)		Deductible, then 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then 0% (tier 1)/30% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$1,000 copay and 0% coinsurance (tier 1)/\$750 copay and 55% coinsurance (tier 2)		Deductible, then 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then 0% (tier 1)/30% (tier 2) coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Medical deductible applies	
Retail pharmacy tier 1 ⁶	35% coinsurance		\$30 copay		0% coinsurance	
Retail pharmacy tier 2 ⁶	35% coinsurance		75/copay		0% coinsurance	
Retail pharmacy tier 3 ⁶	35% coinsurance		20% coinsurance		0% coinsurance	
Retail pharmacy tier 4 ⁶	35% coinsurance		20% coinsurance		0% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$1,000 copay and 0% coinsurance (tier 1)/\$750 copay and 55% coinsurance (tier 2)		Deductible, then 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then 0% (tier 1)/30% (tier 2) coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 35% coinsurance		Deductible, then 20% coinsurance		Deductible, then 0% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

On-exchange plans

	Anthem Silver Pathway X HMO 2850/15% (1X30) ⁸	Anthem Silver Pathway X HMO 3000/10% (1X2U) ⁹	Anthem Silver Pathway X HMO 4250/30% (1X2N) ⁸
Network name ¹	Pathway X HMO		
Plan includes non-network coverage?	No		
Coverage	Network		
Individual deductible ² (Family ³ = 2 x individual amount)	\$2,850	\$3,000	\$4,250
How family deductibles work	Embedded		
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$6,850	\$5,250
Coinsurance ²	15% coinsurance	10% coinsurance	30% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$30 copay per office visit, unlimited	\$40 copay per visit for first 3 office visits, then deductible and 10% coinsurance	\$25 copay per office visit, unlimited
Office visit: specialist*	Deductible, then 15% coinsurance	\$75 copay per visit for first 3 office visits, then deductible and 10% coinsurance	\$50 copay per office visit, unlimited
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 15% coinsurance	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 15% coinsurance	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance
Preventive care ⁴	No additional cost		
Urgent care	Deductible, then \$50 copay and 15% coinsurance	Deductible, then \$50 copay and 10% coinsurance	\$90 copay
Emergency room care	Deductible, then \$500 copay and 15% coinsurance	Deductible, then \$500 copay and 10% coinsurance	Deductible, then 30% coinsurance
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 15% coinsurance	Deductible, then \$500 copay and 10% coinsurance	Deductible, then \$500 copay and 30% coinsurance
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 15% coinsurance	Deductible, then 10% coinsurance	Deductible, then 30% coinsurance
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$500 copay and 15% coinsurance	Deductible, then \$500 copay and 10% coinsurance	Deductible, then \$500 copay and 30% coinsurance
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tier 1: No deductible Tiers 2, 3, 4: \$1,000 Pharmacy deductible
Retail pharmacy tier 1 ⁶	\$20 copay	\$15 copay	\$15 copay
Retail pharmacy tier 2 ⁶	\$50 copay	\$40 copay	\$40 copay
Retail pharmacy tier 3 ⁶	15% coinsurance	10% coinsurance	50% coinsurance
Retail pharmacy tier 4 ⁶	15% coinsurance	10% coinsurance	50% coinsurance
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered		
Mental health and substance abuse: outpatient facility and services	Deductible, then 15% coinsurance		
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$500 copay and 15% coinsurance	Deductible, then \$500 copay and 10% coinsurance	Deductible, then \$500 copay and 30% coinsurance
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 15% coinsurance		
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 15% coinsurance		

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

On-exchange plans

	Anthem Silver Pathway X PPO 2200/15% (1GMB) ⁹		Anthem Silver Pathway X PPO 2000/20% (1GLQ) ⁹		Anthem Silver Pathway X PPO 2500/10% (1GLW) ⁹	
Network name ¹	Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital	
Plan includes non-network coverage?	Yes		Yes		Yes	
Coverage	Network	Non-network	Network	Non-network	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$2,200	\$6,600	\$2,000	\$6,000	\$2,500	\$7,500
How family deductibles work	Embedded		Embedded		Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$20,550	\$6,850	\$20,550	\$6,850	\$20,550
Coinsurance ²	15% coinsurance	45% coinsurance	20% coinsurance	50% coinsurance	10% coinsurance	40% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	Deductible, then 15% coinsurance		\$45 copay per visit for first 2 office visits, then deductible and 20% coinsurance		\$45 copay per office visit, unlimited	
Office visit: specialist*	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	
Preventive care ⁴	No additional cost		No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 15% coinsurance		Deductible, then \$50 copay and 20% coinsurance		Deductible, then \$50 copay and 10% coinsurance	
Emergency room care	Deductible, then \$350 copay and 15% coinsurance		Deductible, then \$350 copay and 20% coinsurance		Deductible, then \$350 copay and 10% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 15% (tier 1)/ 45% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$500 copay and 15% (tier 1)/ 45% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	
Retail pharmacy tier 1 ⁶	\$15 copay		\$15 copay		\$20 copay	
Retail pharmacy tier 2 ⁶	\$40 copay		\$40 copay		\$50 copay	
Retail pharmacy tier 3 ⁶	15% coinsurance		20% coinsurance		10% coinsurance	
Retail pharmacy tier 4 ⁶	15% coinsurance		20% coinsurance		10% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$500 copay and 15% (tier 1)/ 45% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/ 50% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 15% coinsurance		Deductible, then 20% coinsurance		Deductible, then 10% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

On-exchange plans

	Anthem Silver Pathway X PPO 3000/10% (1GL6) ⁹		Anthem Silver Pathway X PPO 3750/0% (1GLJ) ⁹	
Network name ¹	Pathway X Tiered Hospital		Pathway X Tiered Hospital	
Plan includes non-network coverage?	Yes		Yes	
Coverage	Network	Non-network	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$3,000	\$9,000	\$3,750	\$11,250
How family deductibles work	Embedded		Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,000	\$10,000	\$6,500	\$19,500
Coinsurance ²	10% coinsurance	40% coinsurance	0% coinsurance	30% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$40 copay per visit for first 3 office visits, then deductible and 10% coinsurance		\$45 copay per office visit, unlimited	
Office visit: specialist*	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	
Preventive care ⁴	No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 10% coinsurance		Deductible, then \$50 copay and 0% coinsurance	
Emergency room care	Deductible, then \$200 copay and 10% coinsurance		Deductible, then \$200 copay and 0% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/ 30% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/ 30% (tier 2) coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	
Retail pharmacy tier 1 ⁶	10% coinsurance		\$15 copay	
Retail pharmacy tier 2 ⁶	10% coinsurance		\$40 copay	
Retail pharmacy tier 3 ⁶	10% coinsurance		0% coinsurance	
Retail pharmacy tier 4 ⁶	10% coinsurance		0% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$500 copay and 10% (tier 1)/ 40% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/ 30% (tier 2) coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 10% coinsurance		Deductible, then 0% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

On-exchange plans

	Anthem Silver Pathway X PPO 3500/25% (1GM5) ⁹		Anthem Silver Pathway X PPO 10% for HSA (1GLC) ⁸	
Network name ¹	Pathway X Tiered Hospital		Pathway X Tiered Hospital	
Plan includes non-network coverage?	Yes		Yes	
Coverage	Network	Non-network	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$3,500	\$10,500	\$2,600	\$7,800
How family deductibles work	Embedded		Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$5,500	\$16,500	\$5,000	\$15,000
Coinsurance ²	25% coinsurance	50% coinsurance	10% coinsurance	40% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$20 copay per office visit, unlimited		Deductible, then 10% coinsurance	
Office visit: specialist*	\$60 copay per office visit, unlimited		Deductible, then 10% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 25% coinsurance		Deductible, then 10% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 25% coinsurance		Deductible, then 10% coinsurance	
Preventive care ⁴	No additional cost		No additional cost	
Urgent care	\$90 copay		Deductible, then \$50 copay and 10% coinsurance	
Emergency room care	Deductible, then 25% coinsurance		Deductible, then \$200 copay and 10% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 25% coinsurance		Deductible, then 10% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1: No deductible Tiers 2, 3, 4: \$1,000 combined pharmacy deductible		Medical deductible applies	
Retail pharmacy tier 1 ⁶	\$10 copay		10% coinsurance	
Retail pharmacy tier 2 ⁶	\$40 copay		10% coinsurance	
Retail pharmacy tier 3 ⁶	40% coinsurance		10% coinsurance	
Retail pharmacy tier 4 ⁶	40% coinsurance		10% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 25% coinsurance		Deductible, then 10% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 25% coinsurance		Deductible, then 10% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 25% coinsurance		Deductible, then 10% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

On-exchange plans

	Anthem Gold Pathway X HMO 1150/10% (1X39) ¹	Anthem Gold Pathway X HMO 1450/20% (1X36) ¹	Anthem Gold Pathway X PPO 1250/10% (1GM2)	
Network name ¹	Pathway X HMO		Pathway X Tiered Hospital	
Plan includes non-network coverage?	No		Yes	
Coverage	Network	Network	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$1,150	\$1,450	\$1,250	\$3,750
How family deductibles work	Embedded		Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$4,900	\$3,100	\$5,000	\$15,000
Coinsurance ²	10% coinsurance	20% coinsurance	10% coinsurance	40% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$30 copay per office visit, unlimited		\$30 copay per office visit, unlimited	
Office visit: specialist*	\$60 copay per office visit, unlimited		\$75 copay per office visit, unlimited	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Preventive care ⁴	No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 10% coinsurance		\$90 copay	
Emergency room care	Deductible, then \$500 copay and 10% coinsurance		Deductible, then 20% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 10% coinsurance		Deductible, then \$500 copay and 20% coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 10% coinsurance		Deductible, then 20% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then \$500 copay and 10% coinsurance		Deductible, then \$500 copay and 20% coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tier 1: No deductible Tiers 2, 3, 4: \$600 Combined pharmacy deductible	
Retail pharmacy tier 1 ⁶	\$15 copay		\$10 copay	
Retail pharmacy tier 2 ⁶	\$40 copay		\$35 copay	
Retail pharmacy tier 3 ⁶	10% coinsurance		40% coinsurance	
Retail pharmacy tier 4 ⁶	10% coinsurance		40% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 10% coinsurance		Deductible, then 20% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then \$500 copay and 10% coinsurance		Deductible, then \$500 copay and 20% coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 10% coinsurance		Deductible, then 20% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 10% coinsurance		Deductible, then 20% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

On-exchange plans

	Anthem Catastrophic Pathway X PPO 6850/0% (1GKP)	
Network name ¹	Pathway X Tiered Hospital	
Plan includes non-network coverage?	Yes	
Coverage	Network	Non-network
Individual deductible ² (Family ³ = 2 x individual amount)	\$6,850	\$20,550
How family deductibles work	Embedded	
Individual out-of-pocket limit ² (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$20,550
Coinsurance ²	0% coinsurance	30% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) NOTE: other office services subject to deductible and plan coinsurance	\$40 copay per visit for first 3 office visits, then deductible and 0% coinsurance	
Office visit: specialist*	Deductible, then 0% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 0% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 0% coinsurance	
Preventive care ⁴	No additional cost	
Urgent care	Deductible, then 0% coinsurance	
Emergency room care	Deductible, then 0% coinsurance	
Hospital: inpatient admission ⁵ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then 0% coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse) ⁵	Deductible, then 0% coinsurance	
Maternity ⁵ (includes delivery and all inpatient services)	Deductible, then 0% coinsurance	
Retail pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Medical deductible applies	
Retail pharmacy tier 1 ⁶	0% coinsurance	
Retail pharmacy tier 2 ⁶	0% coinsurance	
Retail pharmacy tier 3 ⁶	0% coinsurance	
Retail pharmacy tier 4 ⁶	0% coinsurance	
Dental ⁷ and vision	Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 0% coinsurance	
Mental health and substance abuse: inpatient hospital ⁵	Deductible, then 0% coinsurance	
Chiropractic: office visit (limit of 12 visits per year)	Deductible, then 0% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per year per type of therapy)	Deductible, then 0% coinsurance	

* For plans with PCP and Specialist office visit limits, the visit limits are combined, not separate.

†Pathway X HMO Network is available in the following counties only: Butler, Champaign, Clarke, Clinton, Cuyahoga, Darke, Delaware, Fairfield, Franklin, Geauga, Greene, Knox, Lake, Licking, Lorain, Madison, Medina, Miami, Montgomery, Portage, Preble, Shelby, Summit, Union and Warren. If your clients apply for an HMO plan, they will need to select a network Primary Care Physician (PCP).

1 Tiered hospitals: Our PPO plans offer a Tiered network. Network hospitals are split into two categories, Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1. To see what tier a hospital is in, visit the Find a Doctor tool at anthem.com.

2 PPO plans also include non-network benefits. Our HMO plans only include non-network benefits for emergency care, urgent care and ambulance services.

3 Individual deductible, Individual out-of-pocket limit and coinsurance reflect network/non-network cost share information, if applicable for the plan. All other cost share information is for network services only.

4 LiveHealth Online web visits have the same PCP office visit cost share listed in the chart.

5 For plans with PCP and specialist office visit limits, the visit limits are combined, not separate.

6 Cost share shows Tier 1 / Tier 2 coinsurance for hospitals in our network.

7 For plans with a Retail pharmacy deductible, the pharmacy deductible is separate from the medical deductible. The family deductible is 2 x the individual amount.

8 Pediatric dental is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

9 You may qualify for a tax credit subsidy or cost share reduction on Silver plans you buy on the Health Insurance Marketplace. Check with your Anthem authorized representative for more information and to find out if you qualify for a tax credit or subsidy by purchasing coverage on the Health Insurance Marketplace.

Cost-share reduction plans

	Parent Plan		Cost-Share Reduction Plans					
	Anthem Silver Pathway X PPO 2200/15% (1GMB) ⁹		Anthem Silver Pathway X PPO 2200/15%					
			S04		S05		S06	
Network name ¹	Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital	
Plan includes non-network coverage? ²	Yes		Yes		Yes		Yes	
Coverage	Network	Non-network	Network	Non-network	Network	Non-network	Network	Non-network
Individual deductible ³ (Family = 2 x individual amount)	\$2,200	\$6,600	\$1,750	\$10,000	\$700	\$10,000	\$250	\$10,000
How family deductibles work	Embedded		Embedded		Embedded		Embedded	
Individual out-of-pocket limit (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$20,550	\$4,250	\$16,500	\$1,300	\$16,500	\$550	\$10,000
Coinsurance ³	15% coinsurance	45% coinsurance	15% coinsurance	45% coinsurance	15% coinsurance	45% coinsurance	15% coinsurance	45% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) Note: other office services subject to deductible and plan coinsurance	Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance	
Office visit: specialist ³	Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance	
Preventive care ³	No additional cost		No additional cost		No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 15% coinsurance		Deductible, then \$50 copay and 15% coinsurance		Deductible, then \$50 copay and 15% coinsurance		Deductible, then \$50 copay and 15% coinsurance	
Emergency room care	Deductible, then \$350 copay and 15% coinsurance		Deductible, then \$350 copay and 15% coinsurance		Deductible, then \$350 copay and 15% coinsurance		Deductible, then \$350 copay and 15% coinsurance	
Hospital: inpatient admission ⁶ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 15% (tier 1)/45% (tier 2) coinsurance		Deductible, then \$500 copay and 15% (tier 1)/45% (tier 2) coinsurance		Deductible, then \$250 copay and 15% (tier 1)/45% (tier 2) coinsurance		Deductible, then \$200 copay and 15% (tier 1)/45% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse)	Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance	
Maternity (includes delivery and impatent services.)	Deductible, then \$500 copay and 15% (tier 1)/45% (tier 2) coinsurance		Deductible, then \$500 copay and 15% (tier 1)/45% (tier 2) coinsurance		Deductible, then \$250 copay and 15% (tier 1)/45% (tier 2) coinsurance		Deductible, then \$200 copay and 15% (tier 1)/45% (tier 2) coinsurance	
Retail Pharmacy Deductible ⁷ (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	
Retail pharmacy tier 1	\$15 copay		\$15 copay		\$10 copay		\$10 copay	
Retail pharmacy tier 2	\$40 copay		\$40 copay		\$35 copay		\$35 copay	
Retail pharmacy tier 3	15% coinsurance		15% coinsurance		15% coinsurance		15% coinsurance	
Retail pharmacy tier 4	15% coinsurance		15% coinsurance		15% coinsurance		15% coinsurance	
Dental ⁸ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance	
Mental health and substance abuse: inpatient hospital	Deductible, then \$500 copay and 15% (tier 1)/45% (tier 2) coinsurance		Deductible, then \$500 copay and 15% (tier 1)/45% (tier 2) coinsurance		Deductible, then \$250 copay and 15% (tier 1)/45% (tier 2) coinsurance		Deductible, then \$200 copay and 15% (tier 1)/45% (tier 2) coinsurance	
Chiropractic office visit (For PPO plans: limit of 12 visits per year)	Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per type of therapy)	Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance		Deductible, then 15% coinsurance	

Cost-share reduction plans

	Parent Plan		Cost-Share Reduction Plans					
	Anthem Silver Pathway X PPO 2000/20% (1GLQ) ⁹		Anthem Silver Pathway X PPO 2000/20%					
			S04 (1GLS)		S05 (1GLT)		S06 (1GLU)	
Network name ¹	Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital	
Plan includes non-network coverage? ²	Yes		Yes		Yes		Yes	
Coverage	Network	Non-network	Network	Non-network	Network	Non-network	Network	Non-network
Individual deductible ³ (Family = 2 x individual amount)	\$2,000	\$6,000	\$1,700	\$5,000	\$750	\$5,000	\$200	\$5,000
How family deductibles work	Embedded		Embedded		Embedded		Embedded	
Individual out-of-pocket limit (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$20,550	\$4,500	\$10,000	\$1,500	\$10,000	\$6000	\$10,000
Coinsurance ³	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance	20% coinsurance	50% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) Note: other office services subject to deductible and plan coinsurance	\$45 copay per visit for first 2 office visits, then deductible and 20% coinsurance		\$45 copay per visit for first 2 office visits, then deductible and 20% coinsurance		\$45 copay per visit for first 2 office visits, then deductible and 20% coinsurance		\$45 copay per visit for first 2 office visits, then deductible and 20% coinsurance	
Office visit: specialist ³	Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance	
Preventive care ³	No additional cost		No additional cost		No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 20% coinsurance		Deductible, then \$50 copay and 20% coinsurance		Deductible, then \$50 copay and 20% coinsurance		Deductible, then \$50 copay and 20% coinsurance	
Emergency room care	Deductible, then \$350 copay and 20% coinsurance		Deductible, then \$350 copay and 20% coinsurance		Deductible, then \$350 copay and 20% coinsurance		Deductible, then \$350 copay and 20% coinsurance	
Hospital: inpatient admission ⁶ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/50% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse)	Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance	
Maternity (includes delivery and impatent services.)	Deductible, then \$500 copay and 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/50% (tier 2) coinsurance	
Retail Pharmacy Deductible ⁷ (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	
Retail pharmacy tier 1	\$15 copay		\$15 copay		\$15 copay		\$15 copay	
Retail pharmacy tier 2	\$40 copay		\$40 copay		\$45 copay		\$45 copay	
Retail pharmacy tier 3	20% coinsurance		20% coinsurance		20% coinsurance		20% coinsurance	
Retail pharmacy tier 4	20% coinsurance		20% coinsurance		20% coinsurance		20% coinsurance	
Dental ⁸ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance	
Mental health and substance abuse: inpatient hospital	Deductible, then \$500 copay and 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/50% (tier 2) coinsurance		Deductible, then \$500 copay and 20% (tier 1)/50% (tier 2) coinsurance	
Chiropractic office visit (For PPO plans: limit of 12 visits per year)	Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per type of therapy)	Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance		Deductible, then 20% coinsurance	

Cost-share reduction plans

	Parent Plan		Cost-Share Reduction Plans					
	Anthem Silver Pathway X PPO 2500/10% (1GLW) ⁹		Anthem Silver Pathway X PPO 2500/10%					
			S04 (1GLY)		S05 (1GLZ)		S06 (1GMO)	
Network name ¹	Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital	
Plan includes non-network coverage? ²	Yes		Yes		Yes		Yes	
Coverage	Network	Non-network	Network	Non-network	Network	Non-network	Network	Non-network
Individual deductible ³ (Family = 2 x individual amount)	\$2,500	\$7,500	\$2,250	\$5,000	\$750	\$5,000	\$200	\$5,000
How family deductibles work	Embedded		Embedded		Embedded		Embedded	
Individual out-of-pocket limit (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,850	\$20,550	\$4,500	\$10,000	\$1,500	\$10,000	\$6000	\$10,000
Coinsurance ³	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) Note: other office services subject to deductible and plan coinsurance	\$45 copay per office visit, unlimited		\$45 copay per office visit, unlimited		\$45 copay per office visit, unlimited		\$45 copay per office visit, unlimited	
Office visit: specialist ³	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Preventive care ³	No additional cost		No additional cost		No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 10% coinsurance		Deductible, then \$50 copay and 10% coinsurance		Deductible, then \$50 copay and 10% coinsurance		Deductible, then \$50 copay and 10% coinsurance	
Emergency room care	Deductible, then \$350 copay and 10% coinsurance		Deductible, then \$350 copay and 10% coinsurance		Deductible, then \$350 copay and 10% coinsurance		Deductible, then \$350 copay and 10% coinsurance	
Hospital: inpatient admission ⁶ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Maternity (includes delivery and impatent services.)	Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance	
Retail Pharmacy Deductible ⁷ (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	
Retail pharmacy tier 1	\$20 copay		\$20 copay		\$20 copay		\$20 copay	
Retail pharmacy tier 2	\$50 copay		\$50 copay		\$50 copay		\$50 copay	
Retail pharmacy tier 3	10% coinsurance		10% coinsurance		10% coinsurance		10% coinsurance	
Retail pharmacy tier 4	10% coinsurance		10% coinsurance		10% coinsurance		10% coinsurance	
Dental ⁸ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Mental health and substance abuse: impatient hospital	Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance	
Chiropractic office visit (For PPO plans: limit of 12 visits per year)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per type of therapy)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	

Cost-share reduction plans

	Parent Plan		Cost-Share Reduction Plans					
	Anthem Silver Pathway X PPO 3000/10% (1GL6) ⁹		Anthem Silver Pathway X PPO 3000/10%					
			S04 (1GL8)		S05 (1GL9)		S06 (1GLA)	
Network name ¹	Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital	
Plan includes non-network coverage? ²	Yes		Yes		Yes		Yes	
Coverage	Network	Non-network	Network	Non-network	Network	Non-network	Network	Non-network
Individual deductible ³ (Family = 2 x individual amount)	\$3,000	\$9,000	\$2,500	\$6,000	\$750	\$6,000	\$200	\$6,000
How family deductibles work	Embedded		Embedded		Embedded		Embedded	
Individual out-of-pocket limit (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,000	\$10,000	\$3,500	\$10,000	\$1,650	\$10,000	\$750	\$6,000
Coinsurance ³	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) Note: other office services subject to deductible and plan coinsurance	\$40 copay per visit for first 3 office visits, then deductible and 10% coinsurance		\$40 copay per visit for first 3 office visits, then deductible and 10% coinsurance		\$40 copay per visit for first 3 office visits, then deductible and 10% coinsurance		\$40 copay per visit for first 3 office visits, then deductible and 10% coinsurance	
Office visit: specialist ³	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Preventive care ³	No additional cost		No additional cost		No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 10% coinsurance		Deductible, then \$50 copay and 10% coinsurance		Deductible, then \$50 copay and 10% coinsurance		Deductible, then \$50 copay and 10% coinsurance	
Emergency room care	Deductible, then \$200 copay and 10% coinsurance		Deductible, then \$200 copay and 10% coinsurance		Deductible, then \$200 copay and 10% coinsurance		Deductible, then \$200 copay and 10% coinsurance	
Hospital: inpatient admission ⁶ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Maternity (includes delivery and impatent services.)	Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance	
Retail Pharmacy Deductible ⁷ (for tiers with deductible, cost share applies after deductible)	Medical deductible applies		Medical deductible applies		Medical deductible applies		Medical deductible applies	
Retail pharmacy tier 1	10% coinsurance		10% coinsurance		10% coinsurance		10% coinsurance	
Retail pharmacy tier 2	10% coinsurance		10% coinsurance		10% coinsurance		10% coinsurance	
Retail pharmacy tier 3	10% coinsurance		10% coinsurance		10% coinsurance		10% coinsurance	
Retail pharmacy tier 4	10% coinsurance		10% coinsurance		10% coinsurance		10% coinsurance	
Dental ⁸ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Mental health and substance abuse: impatient hospital	Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance	
Chiropractic office visit (For PPO plans: limit of 12 visits per year)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per type of therapy)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	

Cost-share reduction plans

	Parent Plan		Cost-Share Reduction Plans					
	Anthem Silver Pathway X PPO 3750/0% (1GLJ) ⁹		Anthem Silver Pathway X PPO 3750/0%					
			S04 (1GLL)		S05 (1GLM)		S06 (1GLN)	
Network name ¹	Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital	
Plan includes non-network coverage? ²	Yes		Yes		Yes		Yes	
Coverage	Network	Non-network	Network	Non-network	Network	Non-network	Network	Non-network
Individual deductible ³ (Family = 2 x individual amount)	\$3,750	\$11,250	\$3,000	\$7,000	\$850	\$7,000	\$200	\$7,000
How family deductibles work	Embedded		Embedded		Embedded		Embedded	
Individual out-of-pocket limit (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$6,500	\$19,500	\$4,000	\$10,500	\$1,500	\$10,500	\$650	\$10,500
Coinsurance ³	0% coinsurance	30% coinsurance	0% coinsurance	30% coinsurance	0% coinsurance	30% coinsurance	0% coinsurance	30% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) Note: other office services subject to deductible and plan coinsurance	\$45 copay per office visit, unlimited		\$45 copay per office visit, unlimited		\$45 copay per office visit, unlimited		\$45 copay per office visit, unlimited	
Office visit: specialist ³	Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance	
Preventive care ³	No additional cost		No additional cost		No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 0% coinsurance		Deductible, then \$50 copay and 0% coinsurance		Deductible, then \$50 copay and 0% coinsurance		Deductible, then \$50 copay and 0% coinsurance	
Emergency room care	Deductible, then \$200 copay and 0% coinsurance		Deductible, then \$200 copay and 0% coinsurance		Deductible, then \$200 copay and 0% coinsurance		Deductible, then \$200 copay and 0% coinsurance	
Hospital: inpatient admission ⁶ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 0% (tier 1)/30% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/30% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/30% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/30% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse)	Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance	
Maternity (includes delivery and inpatient services.)	Deductible, then \$500 copay and 0% (tier 1)/30% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/30% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/30% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/30% (tier 2) coinsurance	
Retail Pharmacy Deductible ⁷ (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies		Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	
Retail pharmacy tier 1	\$15 copay		\$15 copay		\$15 copay		\$15 copay	
Retail pharmacy tier 2	\$40 copay		\$40 copay		\$40 copay		\$40 copay	
Retail pharmacy tier 3	0% coinsurance		0% coinsurance		0% coinsurance		0% coinsurance	
Retail pharmacy tier 4	0% coinsurance		0% coinsurance		0% coinsurance		0% coinsurance	
Dental ⁸ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance	
Mental health and substance abuse: inpatient hospital	Deductible, then \$500 copay and 0% (tier 1)/30% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/30% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/30% (tier 2) coinsurance		Deductible, then \$500 copay and 0% (tier 1)/30% (tier 2) coinsurance	
Chiropractic office visit (For PPO plans: limit of 12 visits per year)	Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per type of therapy)	Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance		Deductible, then 0% coinsurance	

Cost-share reduction plans

	Parent Plan		Cost-Share Reduction Plans					
	Anthem Silver Pathway X PPO 3500/25% (1GM5) ⁹		Anthem Silver Pathway X PPO 3500/25%					
			S04 (1GM6)		S05 (1GM7)		S05 (1GM7)	
Network name ¹	Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital	
Plan includes non-network coverage? ²	Yes		Yes		Yes		Yes	
Coverage	Network	Non-network	Network	Non-network	Network	Non-network	Network	Non-network
Individual deductible ³ (Family = 2 x individual amount)	\$3,500	\$10,500	\$2,250	\$7,000	\$750	\$7,000	\$250	\$7,000
How family deductibles work	Embedded		Embedded		Embedded		Embedded	
Individual out-of-pocket limit (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$5,500	\$16,500	\$4,650	\$14,000	\$1,500	\$14,000	\$600	\$14,000
Coinsurance ³	25% coinsurance	50% coinsurance	25% coinsurance	50% coinsurance	25% coinsurance	50% coinsurance	25% coinsurance	50% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) Note: other office services subject to deductible and plan coinsurance	\$20 copay per office visit, unlimited		\$20 copay per office visit, unlimited		\$20 copay per office visit, unlimited		\$20 copay per office visit, unlimited	
Office visit: specialist ³	\$60 copay per office visit, unlimited		\$60 copay per office visit, unlimited		\$60 copay per office visit, unlimited		\$60 copay per office visit, unlimited	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance	
Preventive care ³	No additional cost		No additional cost		No additional cost		No additional cost	
Urgent care	\$90 copay		\$90 copay		\$90 copay		\$90 copay	
Emergency room care	Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance	
Hospital: inpatient admission ⁶ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 25% coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse)	Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance	
Maternity (includes delivery and inpatient services.)	Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 25% coinsurance	
Retail Pharmacy Deductible ⁷ (for tiers with deductible, cost share applies after deductible)	Tier 1: No deductible Tiers 2, 3, 4: \$1,000 Combined pharmacy deductible		Tier 1: No deductible Tiers 2, 3, 4: \$1,000 Combined pharmacy deductible		Tier 1: No deductible Tiers 2, 3, 4: \$1,000 Combined pharmacy deductible		Tier 1: No deductible Tiers 2, 3, 4: \$1,000 Combined pharmacy deductible	
Retail pharmacy tier 1	\$10 copay		\$10 copay		\$10 copay		\$10 copay	
Retail pharmacy tier 2	\$40 copay		\$40 copay		\$40 copay		\$40 copay	
Retail pharmacy tier 3	40% coinsurance		40% coinsurance		40% coinsurance		40% coinsurance	
Retail pharmacy tier 4	40% coinsurance		40% coinsurance		40% coinsurance		40% coinsurance	
Dental ⁸ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance	
Mental health and substance abuse: inpatient hospital	Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 25% coinsurance		Deductible, then \$500 copay and 25% coinsurance	
Chiropractic office visit (For PPO plans: limit of 12 visits per year)	Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per type of therapy)	Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance		Deductible, then 25% coinsurance	

Cost-share reduction plans

	Parent Plan		Cost-Share Reduction Plans					
	Anthem Silver Pathway X PPO 10% for HSA (1GLC) ⁹		Anthem Silver Pathway X PPO 10% for HSA					
			S04 (28Z0)		S05 (1GLF)		S05 (1GLG)	
Network name ¹	Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital		Pathway X Tiered Hospital	
Plan includes non-network coverage? ²	Yes		Yes		Yes		Yes	
Coverage	Network	Non-network	Network	Non-network	Network	Non-network	Network	Non-network
Individual deductible ³ (Family = 2 x individual amount)	\$2,600	\$7,800	\$2,000	\$8,000	\$1,150	\$5,000	\$500	\$5,000
How family deductibles work	Embedded		Embedded		Embedded		Embedded	
Individual out-of-pocket limit (Includes deductible, copays, coinsurance and pharmacy. Family = 2 x individual amount)	\$5,000	\$15,000	\$4,000	\$10,000	\$1,150	\$10,000	\$500	\$10,000
Coinsurance ³	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Office visit: primary care physician (PCP) (includes postnatal visits) Note: other office services subject to deductible and plan coinsurance	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Office visit: specialist ⁴	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Outpatient diagnostic tests (Examples: X-ray, EKG)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Outpatient advanced diagnostic tests (Examples: MRI, CT scan)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Preventive care ⁵	No additional cost		No additional cost		No additional cost		No additional cost	
Urgent care	Deductible, then \$50 copay and 10% coinsurance		Deductible, then \$50 copay and 10% coinsurance		Deductible, then \$50 copay and 10% coinsurance		Deductible, then \$50 copay and 10% coinsurance	
Emergency room care	Deductible, then \$200 copay and 10% coinsurance		Deductible, then \$200 copay and 10% coinsurance		Deductible, then \$200 copay and 10% coinsurance		Deductible, then \$200 copay and 10% coinsurance	
Hospital: inpatient admission ⁶ (e.g. hospital room) (includes maternity, mental health and substance abuse)	Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance	
Hospital: outpatient facility (includes surgery, maternity, mental health and substance abuse)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Maternity (includes delivery and inpatient services.)	Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance	
Retail Pharmacy Deductible ⁷ (for tiers with deductible, cost share applies after deductible)	Medical deductible applies		Medical deductible applies		Medical deductible applies		Medical deductible applies	
Retail pharmacy tier 1	10% coinsurance		10% coinsurance		10% coinsurance		10% coinsurance	
Retail pharmacy tier 2	10% coinsurance		10% coinsurance		10% coinsurance		10% coinsurance	
Retail pharmacy tier 3	10% coinsurance		10% coinsurance		10% coinsurance		10% coinsurance	
Retail pharmacy tier 4	10% coinsurance		10% coinsurance		10% coinsurance		10% coinsurance	
Dental ⁸ and vision	Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered		Pediatric dental and vision covered Adult dental and vision not covered	
Mental health and substance abuse: outpatient facility and services	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Mental health and substance abuse: inpatient hospital	Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance		Deductible, then \$500 copay and 10% (tier 1)/40% (tier 2) coinsurance	
Chiropractic office visit (For PPO plans: limit of 12 visits per year)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	
Physical, occupational and speech therapy (limit of 20 visits per type of therapy)	Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance		Deductible, then 10% coinsurance	

1 Tiered hospitals: Our PPO plans offer a tiered network. Network hospitals are split into two categories, Tier 1 and Tier 2. Your clients pay a lower cost share for hospitals in Tier 1. To see what tier a hospital is in, visit the Find a Doctor tool at [anthem.com](https://www.anthem.com).

2 PPO plans also include non-network benefits. Our HMO plans only include non-network benefits for emergency care, urgent care and ambulance services.

3 Individual deductible, individual out-of-pocket limit and coinsurance reflect network/non-network cost share information, if applicable for the plan. All other cost share information is for network services only.

4 LiveHealth Online web visits have the same PCP office visit cost share listed in the chart.

5 For plans with PCP and specialist office visit limits, the visit limits are combined, not separate.

6 Cost share shows Tier 1/Tier 2 coinsurance for hospitals in our network.

7 For plans with a retail pharmacy deductible, the pharmacy deductible is separate from the medical deductible. The family deductible is 2 x the individual amount.

8 Pediatric dental is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

Off-exchange plans

1 Anthem PPO plans also include non-network benefits. Our HMO plans only include non-network benefits for emergency care, urgent care and ambulance services.

2 Our plans, have embedded family deductibles where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

3 LiveHealth Online web visits have the same PCP office visit cost share listed in the chart.

4 Nationally recommended preventive care services received in-network have no copay and no deductible requirement. Preventive care services consist of services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

5 Prescription drugs: Your clients will use our home delivery pharmacy, managed by Express Scripts, Inc., instead of a retail pharmacy, for drugs your client take on a routine basis (e.g. maintenance medicines). If they are taking a maintenance medication, they may get the first 30-day supply plus one additional 30-day refill of the same maintenance medication at thier local retail pharmacy. Your cleints must then use the home delivery pharmacy.

6 Prescription drugs: Covered medications are assigned to certain tiers (or levels) based on cost, availability and similar alternatives. Our plans have multiple tiers. Tier 1 medications may have a lower cost share for the member.

7 Pediatric dental is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

8 The pediatric dental policy DOES NOT provide any dental benefits to individuals age nineteen (19) or older. The pediatric dental policy is offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. A person age nineteen (19) or older will need to buy a separate adult plan if they want adult dental benefits. The pediatric dental policy WILL NOT pay for any adult dental care.

In compliance with the Affordable Care Act rules, benefits, formulary, pharmacy network, provider network, premium, copay and coinsurance for these plans may change on January 1 of each year.

Anthem does not discriminate based on race, color, ethnicity, national origin, religion, age, gender, gender identity, mental or physical disabilities, sexual orientation, genetic information, including pregnancy and expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health condition or health status in the administration of the plan, including enrollment, marketing practices, benefit designs, and benefit determinations.

On-exchange plans

1 Anthem PPO Network plans also include non-network benefits. Our HMO plans only include non-network benefits for emergency care, urgent care and ambulance services.

2 Our plans, have embedded family deductibles where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

3 LiveHealth Online web visits have the same PCP office visit cost share listed in the chart.

4 Nationally recommended preventive care services received in-network have no copay and no deductible requirement. Preventive care services consist of services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

5 Prescription drugs: Your clients will use our home delivery pharmacy, managed by Express Scripts, Inc., instead of a retail pharmacy, for drugs your cleints take on a routine basis (e.g. maintenance medicines). If they are taking a maintenance medication, they may get the first 30-day supply plus one additional 30-day refill of the same maintenance medication at thier local retail pharmacy. Your clients must then use the home delivery pharmacy.

6 Prescription drugs: Covered medications are assigned to certain tiers (or levels) based on cost, availability and similar alternatives. Our plans have multiple tiers. Tier 1 medications may have a lower cost share for the member.

7 Pediatric dental is included in the medical plan. These dental benefits are subject to the medical plan's deductible and out-of-pocket limit.

8 The pediatric dental policy DOES NOT provide any dental benefits to individuals age nineteen (19) or older. The pediatric dental policy is offered so the purchaser will have pediatric dental coverage as required by the Affordable Care Act. A person age nineteen (19) or older will need to buy a separate adult plan if they want adult dental benefits. The pediatric dental policy WILL NOT pay for any adult dental care.

Your client may be able to get more cost-savings subsidies on Silver plans. Check with your Anthem authorized representative for more information and to find out if you qualify for a tax credit or subsidy. Visit <https://www.healthcare.gov/will-i-qualify-to-save-on-monthly-premiums/> for more information.

In compliance with the Affordable Care Act rules, benefits, formulary, pharmacy network, provider network, premium, copay and coinsurance for these plans may change on January 1 of each year.

NOTES

Horizontal lines for notes.

Dental benefits with extras clients request

We offer a variety of Individual and Family dental plans to fit your clients' health care needs and budget:

- Dental Prime (available off the Marketplace only)
- Anthem Dental Pediatric
- Anthem Dental Family and Anthem Dental Family Enhanced

As part of the Affordable Care Act's pediatric dental benefit, they can pick from three options:

- A medical plan with pediatric dental benefits
- A stand-alone pediatric dental policy (Dental Pediatric plan)
- A stand-alone adult or family dental plan that includes pediatric benefits

Anthem can help your clients get the dental care they need for better overall health. Many of our dental plans include 100% coverage for exams, cleanings and X-rays. Plus, there are benefits for fillings, crowns, root canals, oral surgery and orthodontia.* To see a detailed dental benefit chart, go to the "Dental plan benefit chart" section.



* Benefits vary by plan.

Vision benefits with a large network

We also offer a Blue View VisionSM plan, which your clients can add on to any Anthem medical and/or dental plan. This plan is available off the Marketplace only.

With Blue View Vision, they can get their eye care and eyewear just about anywhere! Our large national vision network gives your clients:

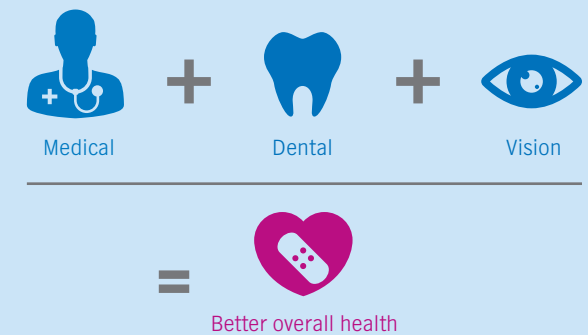
- Over **33,000 eye doctors** at more than 26,000 locations to choose from — so they're sure to find an eye care professional that's close to home or work.
- Access to **1-800 CONTACTS** online or by phone, private practice eye doctors, and in-store visits to **LensCrafters[®], Sears OpticalSM, Target Optical[®], JCPenney[®] Optical** and most **Pearle Vision[®]** locations.

Blue View Vision coverage includes:

- Eye exams once every 12 months
- Standard lenses (single vision, bifocal and trifocal) once every 24 months
- Contact lenses (conventional and disposable) once every 24 months
- Frames once every 24 months
- Lots of additional discounts and benefits

The medical + dental + vision advantage

Coordinating medical, dental and vision plans can result in better care — delivered sooner and at a lower cost. Plus, your clients enjoy the convenience of having only one ID card and one bill when they purchase all their coverage from Anthem.



Dental plans*

	Anthem Dental Pediatric	Anthem Dental Family (Dependents age 18 and younger)	Anthem Dental Family (Adults age 19+)
	In-network/Non-network	In-network/Non-network	In-network/Non-network
Dental Network	Dental Prime	Dental Prime	Dental Prime
Deductible (per person, all services) ¹	\$50/\$50	\$50/\$50	\$50/\$50
Annual maximum (per person) ²	None	None	\$750/\$750
Annual out-of-pocket limit	\$350 ³ /None	\$350 ³ /None	None
Diagnostic and preventive	No waiting period	No waiting period	No waiting period
Cleaning, exams, x-rays	0%/30% coinsurance	0%/30% coinsurance	0%/50% coinsurance
Extra cleaning	Not covered	Not covered	Not covered
Basic services	No waiting period	No waiting period	6-month waiting period
Fillings	40%/50% coinsurance	40%/50% coinsurance	50%/75% coinsurance
Complex and major services	No waiting period ⁴	No waiting period ⁴	12-month waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	50%/50% coinsurance	50%/50% coinsurance	70%/85% coinsurance
Prosthetics (crowns, dentures, bridges)	50%/50% coinsurance	50%/50% coinsurance	70%/85% coinsurance
Medically necessary orthodontia	50%/50% coinsurance	50%/50% coinsurance	Not covered
Cosmetic orthodontia	Not covered	Not covered	Not covered
International emergency dental program	Included	Included	Included

Dental plans

* Unless stated otherwise these plans are available on and off the Exchange.

1 In-network and non-network deductibles are separate and do not count toward each other. For example, if you've met your in-network deductible, but then decide to use a non-network provider for another service, you'll need to meet the entire non-network deductible.

2 With our Dental Blue Plans, the deductible is waived for diagnostic and preventive services received in our network.

3 Per child, up to two children.

4 Except 12-month waiting period for medically necessary and cosmetic orthodontia.

5 \$1,000 lifetime maximum for cosmetic orthodontia.

Anthem does not discriminate based on race, color, ethnicity, national origin, religion, age, gender, gender identity, mental or physical disabilities, sexual orientation, genetic information, including pregnancy and expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health condition or health status in the administration of the plan, including enrollment, marketing practices, benefit designs, and benefit determinations.

Dental plans*

	Anthem Dental Family Enhanced (Dependents age 18 and younger)	Anthem Dental Family Enhanced (Adults age 19+)
	In-network/Non-network	In-network/Non-network
Dental Network	Dental Prime	Dental Prime
Deductible (per person, all services) ¹	\$25/\$25	\$50/\$50
Annual maximum (per person) ²	None	\$1,000/\$1,000
Annual out-of-pocket limit	\$350 ³ /None	None
Diagnostic and preventive	No waiting period	No waiting period
Cleaning, exams, x-rays	0%/20% coinsurance	0%/50% coinsurance
Extra cleaning	Not covered	Not covered
Basic services	No waiting period	6-month waiting period
Fillings	20%/40% coinsurance	20%/60% coinsurance
Complex and major services	No waiting period ⁴	12-month waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	20%/50% coinsurance	50%/75% coinsurance
Prosthetics (crowns, dentures, bridges)	50%/50% coinsurance	50%/75% coinsurance
Medically necessary orthodontia	50%/50% coinsurance	Not covered
Cosmetic orthodontia	50%/50% coinsurance ⁵	Not covered
International emergency dental program	Included	Included

Dental plans

* Unless stated otherwise these plans are available on and off the Exchange.

1 In-network and non-network deductibles are separate and do not count toward each other. For example, if you've met your in-network deductible, but then decide to use a non-network provider for another service, you'll need to meet the entire non-network deductible.

2 With our Dental Blue Plans, the deductible is waived for diagnostic and preventive services received in our network.

3 Per child, up to two children.

4 Except 12-month waiting period for medically necessary and cosmetic orthodontia.

5 \$1,000 lifetime maximum for cosmetic orthodontia.

Anthem does not discriminate based on race, color, ethnicity, national origin, religion, age, gender, gender identity, mental or physical disabilities, sexual orientation, genetic information, including pregnancy and expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health condition or health status in the administration of the plan, including enrollment, marketing practices, benefit designs, and benefit determinations.

Dental plans*

	Dental Smart Access Plan A	Dental Smart Access Plan B	Dental Smart Access Plan C
	In-network/Non-network	In-network/Non-network	In-network/Non-network
Dental Network	Smart Access	Smart Access	Smart Access
Deductible (per person, all services) ¹	\$50/\$50	\$50/\$50	\$50/\$50
Annual maximum (per person) ¹	\$750/\$750	\$1,000/\$1,000	\$1,250/\$1,250
Annual out-of-pocket limit	None	None	None
Diagnostic and preventive	No waiting period	No waiting period	No waiting period
Cleaning, exams, x-rays	0%/50% coinsurance	0%/50% coinsurance	0%/50% coinsurance
Extra cleaning	Not covered	Not covered	Not covered
Basic services	6-month waiting period	6-month waiting period	6-month waiting period
Fillings	50%/75% coinsurance	50%/75% coinsurance	20%/60% coinsurance
Complex and major services	12-month waiting period	12-month waiting period	12-month waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	Not covered	70% coinsurance/85% coinsurance	50%/75% coinsurance
Prosthetics (crowns, dentures, bridges)	Not covered	70% coinsurance/85% coinsurance	50%/75% coinsurance
Medically necessary orthodontia	Not covered	Not covered	Not covered
Cosmetic orthodontia	Not covered	Not covered	Not covered
International emergency dental program	Included	Included	Included

Dental plans

* Unless stated otherwise these plans are available on and off the Exchange.

1 In-network and non-network deductibles are separate and do not count toward each other. For example, if you've met your in-network deductible, but then decide to use a non-network provider for another service, you'll need to meet the entire non-network deductible.

2 With our Dental Blue Plans, the deductible is waived for diagnostic and preventive services received in our network.

3 Per child, up to two children.

4 Except 12-month waiting period for medically necessary and cosmetic orthodontia.

5 \$1,000 lifetime maximum for cosmetic orthodontia.

Anthem does not discriminate based on race, color, ethnicity, national origin, religion, age, gender, gender identity, mental or physical disabilities, sexual orientation, genetic information, including pregnancy and expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health condition or health status in the administration of the plan, including enrollment, marketing practices, benefit designs, and benefit determinations.

Dental plans*

	Dental Blue Basic 100	Dental Blue Essential 100	Dental Blue Essential 200
	In-network/Non-network	In-network/Non-network	In-network/Non-network
Dental Network	Dental Blue 100	Dental Blue 100	Dental Blue 200
Deductible (per person, all services) ¹	\$50/\$50 ²	\$50/\$50 ²	\$50/\$50 ²
Annual maximum (per person) ¹	\$500/\$500	\$1,000/\$1,000	\$1,000/\$1,000
Annual out-of-pocket limit	None	None	None
Diagnostic and preventive	No waiting period	No waiting period	No waiting period
Cleaning, exams, x-rays	0% coinsurance/Fee schedule	0% coinsurance/Fee schedule	0% coinsurance/Fee schedule
Extra cleaning	Not covered	Not covered	Not covered
Basic services	No waiting period	No waiting period	No waiting period
Fillings	20% coinsurance/Fee schedule	Fee schedule	Fee schedule
Complex and major services	12-month waiting period	12-month waiting period	12-month waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	Not covered	Fee schedule	Fee schedule
Prosthetics (crowns, dentures, bridges)	Not covered	Fee schedule	Fee schedule
Medically necessary orthodontia	Not covered	Not covered	Not covered
Cosmetic orthodontia	Not covered	Not covered	Not covered
International emergency dental program	Included	Included	Included

Dental plans

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Exclusions and limitations you need to know

The specific exclusions are spelled out in your clients' particular plan, but common services not covered by these plans are:

- Artificial insemination, fertilization, infertility drugs or sterilization reversal
- Artificial and mechanical hearts
- Benefits covered by Medicare or a governmental program
- Breast reduction or augmentation
- Care provided by a member of the family
- Care received in an emergency room that is not emergency care, except as specified in your clients' Agreement
- 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 permits for services)
- Comfort and/or convenience items
- Cosmetic surgery and/or treatment that's primarily intended to improve your appearance
- Custodial care
- Dental, except as described in your clients' Agreement
- Educational services
- Experimental or investigative treatment
- Health club memberships and fitness services
- Infertility testing and treatment (this is covered for HMO)
- Nutritional and dietary supplements
- Over-the-counter drugs, devices or products, except as mandated
- Pharmacy, except as described in your clients' Agreement
- 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 your clients' Agreement
- Weight loss programs or treatment of obesity, except as mandated
- Workers' compensation

NOTES



The plan details in this guide are a summary for informational and comparison purposes only.
For more details, please view the Summary of Benefits and Coverage (SBC) at www.sbc.anthem.com.

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